Clinical Lecture
ON
CASES OF PROLONGED SOMNOLENCE IN CEREBRAL SYPHILIS.

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THERE is a kind of stupor which is a noteworthy feature in many cases of intracranial syphilis. It was particularly marked in a man named B——, who is now attending the hospital as an out-patient, and was an inmate last year. The condition is sometimes much prolonged, extending, it may be, over several weeks, during which time it appears as though life were being carried on almost automatically. On recovery, however, should that take place, it is found that the patient has been conscious of his surroundings to an extent which is somewhat surprising. John B——, aged forty-one, was admitted into the hospital after having attended as an out-patient during two months. His illness had been of this kind: after very bad pain in the head for a week, he had a sudden attack of right hemiplegia, without loss of consciousness. He was gradually recovering from this, when he came to the hospital two months afterwards, and there then remained little to be seen but a slight traction of the mouth towards the left side. There was also paralysis of the right external rectus muscle, of the duration of which we could get no account. His limbs were of equal strength. He had never lost, however, and still suffered greatly from, pain in his head. Whilst attending as an out-patient he took thirty grains of iodide of potassium daily for two months, but at the end of that time, when he was admitted into hospital, his head was as bad as ever, and he looked ill. I should say that not only was there a clear history of syphilis in his case, but one of his legs presented a scar which was very characteristic of old specific ulceration.

When this man came into the hospital it was noted by Mr. Broster, our resident medical officer, that his mental power seemed to be much dulled, his answers slow, and his manner apathetic. He would sleep nearly the whole day, and if he occasionally roused himself, would take a few steps in a dazed condition, and then, as likely as not, try to get into some other patient's bed. He volunteered no remark. Nine days afterwards the story was much the same. "He rarely, if ever, speaks to anyone, but sits silent or lies down the whole day. He understands apparently what is said to him, and does what he is told, but any reply which he makes to a question is slow, hesitating, and often not to the purpose. He sleeps very much. He was wandering in a vague way to the door this morning, and on being asked his motive, said, 'I should like to go home, but I don't know where I live.'"

Ten days after this note had been made he had a sudden seizure, in which he is thought to have partly lost consciousness, and became for a second time paralysed in his right limbs, and coincidently the left external rectus muscle ceased to act. After this attack the patient was unable to stand; usually very drowsy, he was sometimes restless, complaining (only when questioned) of pain in the head. He was ordered a grain of blue pill, which he took twice a day for six days, but this peculiar state of stupor growing manifestly worse, I directed that he should be rubbed in daily with mercurial ointment. A week later, and it is noted that his pulse is small and weak, the extremities cold, the respiration slow and stertorous. He is conscious, but has no power to do anything, and will not take nourishment. His urine and fæces are passed under him in the bed. For the next two days his condition appeared to be one of imminent danger, and his friends were summoned. Then some dysenteric symptoms, due, doubtless, to the mercury, showed themselves, and almost simultaneously his mind rather rapidly cleared; he got up, walked without much difficulty, gradually recovering the lost power in his right limbs. The left external rectus muscle, too, again began to act. Ten days later, and Mr. Broster notes: "He is up and about, taking a lively interest in everything, and as quick at repartee as anyone in the ward. He remembers all that was said to him at a time when he was so restless as to require restraint in bed, and says that he was under the impression that some one was trying to murder him." The state of stupor had lasted upwards of five weeks. When the patient was discharged, some three or four weeks later, he had recovered completely the use of his limbs, was in good general health, with clear intellect, and about a month later the paralysis of the right external rectus muscle cleared up also. He told us the other day that he could walk five miles. He is still kept under observation as an out-patient, and a slight mercurial influence has been continued.

Now when I said that this kind of stupor was a noteworthy feature in many cases of intracranial syphilis, I did not mean to imply that the condition was of *itself* pathognomonic of syphilis. This is evidently not the case. We often see mental obfuscation of this kind in an old man or woman who has had an apoplectic seizure, especially when this has been due to the thrombosing of atheromatous arteries. But in these latter cases two things must be remembered: in the first place the patient is old, and in the next place more often than not he does not recover. What is peculiar to the syphilitic cases is that the patient is usually young, and that he very frequently recovers.

John B—— is only forty-one. His radial and temporal arteries are elastic, he has no cardiac disease, there is no albumen in his urine. He is not only, therefore, young in years, but in his tissues also, except, however, in one most important quarter—the arteries of his brain. The history goes to show that there is thickening of some of his cerebral arteries, and that this is of syphilitic origin. I suppose that each of his hemiplegic attacks was the result of a limited brain-softening consequent upon thrombosis of an artery the channel of which had been much narrowed by inflammation and thickening of its walls. Now the question may be asked, How do you know that the hemiplegia was not due to the pressure of a gummatous tumour upon the motor tract or upon the surface of a cerebral hemisphere, instead of to thrombotic softening? Such a question is sometimes difficult, it may be impossible, to be answered. But the present case admits, I think, of but little doubt. The man had a sudden seizure of paralysis—a hemiplegia without loss of consciousness, at a time when he was, so to speak, saturated with iodine. Whatever may have been the cause of his first attack of hemiplegia, which occurred two months before he came here, it is scarcely conceivable that a gumma would not only grow, but attain a destructive size, in a patient taking thirty grains of iodide daily. Added to which, the sudden mode of seizure is in favour of softening from thrombosis, and opposed to the hypothesis of its being occasioned by a growth. Nor did the ophthalmoscope give evidence of the presence of a tumour. There was no optic neuritis. We may take it, then, as tolerably certain that this man's hemiplegic seizure was the result of arterial disease. The symptoms seemed to show (by exclusion) that the paralysis of the sixth nerve was due to a separate lesion, but upon this we need not now dwell.

It is the occurrence, then, of long-continued stupor with symptoms of thrombosis in a *young* man—in a man who, at least, shows no sign of agedness,—and his eventual recovery, which are so significant of syphilis. Moreover, such cases are not at all uncommon. I have reason to think that they very often represent the "brain fever" and the "sunstroke" of the public. The condition becomes even more striking when it occurs in a person of still younger age. Richard S—— has come here at my request, a year after his discharge from the hospital, in order that we may learn how he has gone on. Only thirty-one years of age, he had been brought to the hospital in September, 1877, in a cab, just able to stand. He had left hemiplegia, with partial ptosis and paralysis of the superior rectus muscle of the right eye. This was the manifest condition on his admission, but his mind was so dull that but few particulars could be obtained from him till some time afterwards. He had a dazed look, and could not take in an idea until it had been told to him many times. He did not initiate any conversation, but in reply to questions said that he had a very bad pain in the head and felt weak and sleepy. Having gone to bed, he lay there for a month, silent and somnolent. He took thirty, and later sixty, grains of iodide daily. About four weeks after his

admission he had become somewhat less stupid and heavy, but he still complained of much pain in the head. He was now rubbed in regularly with mercurial ointment, the iodide being discontinued. When the gums became tender, which did not take place for a month, it is noted that his mind had cleared up, he had nearly lost the pain, his limbs had become stronger, and in the course of three weeks he left the hospital, perfectly recovered from his hemiplegia. When he came to us at my request the other day, he told us that he had remained perfectly well, was able to walk, and in September last had won the prize in a rowing match on the river.

Let me here refer briefly to the previous history of this patient, which embraced the following important circumstances:—A chancre eleven years previously, which was followed by sore-throat and skin eruption. Early in 1876 severe pains in the left lower extremity, styled and treated as "rheumatic," but accompanied by paralysis, cutaneous anæsthesia, and wasting, so that he was left, after six months' illness, with a thigh permanently some three inches and a half less in circumference than the right, and the skin of this limb anæsthetic. He had returned to his work (with a lamed leg) not more than three months when he was taken with pain across the forehead and vomiting, which occurred several times a day, irrespective of food. The vomiting, he says, was ascribed by his medical attendant to "biliousness," but it went on for three or four months, accompanied by the constant pain. It was no doubt of cerebral origin. Then he was seized with ptosis of the right eyelid, and a month later with a gradually increasing left hemiplegia, for which he was admitted here. It should be added that he presented no signs of heart or kidney disease. The ophthalmoscopic evidence was not decisive. There was certainly no optic neuritis at the time of examination, but the appearance of the fundus oculi led me to think that there might have been some at a previous date.

The occurrence of two distinct lesions, as in this case, one evidently in the cauda equina of the spinal cord, the other in the cranial cavity, in a young and otherwise healthy man with a syphilitic history, is conclusive as to the specific character of the hemiplegia. Of the exact mode in which the hemiplegia was brought about we cannot speak with equal certainty. If there were, as in some respects would seem likely, a syphilitic tumour of the right crus cerebri, this, probably, also involved and obstructed a part of the circle of Willis. I mean that the man presented symptoms of obstructed cerebral circulation not to be explained by the simple compression of the crus cerebri by a tumour. But whether an artery had been blocked as a result of inflammatory thickening of its walls, or from its having become involved in a gummatous tumour, must remain doubtful.

I need not say that the mental condition which I have illustrated—a state of obfuscation and somnolence not amounting to coma, but lasting in each case for several weeks—is not an ordinary accompaniment of hemiplegia. It is a condition, however, which one has every now and then seen in cases, also due to syphilis, the result of which has not been so fortunate as those described. In such cases we have found after death some of the arteries at the base of the brain remarkably thickened, and their channels blocked with thrombi, the brain substance itself in the district of their distribution being more or less extensively softened. Now I should suppose that if we could have peeped into B——'s cranium shortly after his admission, and explored the base of his brain, we should have found, perhaps one, perhaps several, of the cerebral arteries thickened in their walls by syphilitic new growth. This thickening of the walls—usually of a nodular character—narrows the channel, it may be to a very great extent, so that, whilst being still pervious, the tube is reduced in internal diameter to a fraction of its normal calibre. The elasticity of the vessel is, moreover, almost removed, so that the blood has to find its way, as best it can, through a comparatively unyielding tube of unnaturally small diameter. The resistance thus offered to the current of blood must result in the district to which the vessel is distributed receiving a much smaller quantity in a given time than is natural. So far as I can see, the compensatory action of the circle of Willis is only brought into effect on the occurrence of obstruction in one or other of the arteries below it (internal carotid, vertebral), and is of no avail when obstruction occurs in arteries proceeding from it. The consequence would appear to be that the cortical substance of the hemisphere must be starved of blood to a considerable extent. We can easily conceive that this starvation may stop short of death of the tissue—that is to say, there may not be absolute obstruction and consequent softening, but a state of partial atrophy; and either this or a consequent effusion of liquid to supply the place of shrunken convolutions may possibly explain the peculiar condition of somnolence and half consciousness. As regards the attack of hemiplegia which B—— experienced soon after his admission, I should think that it was the result of a limited softening of the brain consequent upon a thrombus absolutely blocking up one of these narrowed vessels. Such an accident would produce an actual necrosis of the nerve-substance, whilst the narrowing of the channels alone (if blocking did not take place) might readily occasion a simple impoverishment.

I will not dwell longer upon this point, because our patient's recovery, happily, leaves the matter of necessity in the domain of hypothesis. But I must call attention to a question in therapeutics with reference to the arterial thickening, which appears to be of no small importance. B——, it will be remembered, had been taking thirty grains of iodide daily for two months (a moderate dose), when he broke down in his brain. This drug then, supposing the view taken of the man's pathological state to be correct, had failed to influence the new formation in the arterial walls, so as to prevent the grave consequences of narrowing and thrombosis. No doubt there is the probability that its administration was commenced too late; that changes had taken place in the growth such as rendered its absorption (which might have been practicable at an earlier stage) no longer easy, and there is the possibility, also, that the dose was not large enough. But it is a fact, however it is to be explained, that we very often meet with this condition of thickened arteries in the post-mortem examination of persons who have been taking iodide of potassium up to the time of their death. I have long had a rather strong impression that the iodide has comparatively little effect upon this arterial change, and that it is best to employ mercury without delay in most cases of this kind. At all events, under a really effective use of this drug (administered by inunction) the restoration to health which took place in these patients was most striking. It is not unfair to suppose, although it cannot be proved, that under its use a good deal of the new growth in the arterial walls, which had resisted the effects of the iodide, was absorbed, so that the channels of circulation became gradually liberated to a great extent.

It is only, of course, through the medium of the patient's symptoms that we are able to infer that a cerebral artery which has been the seat of obstruction is again permitting the free circulation of blood through it. The artery itself is far away out of reach of the touch or the sight. But I think it is legitimate to assume that what we see occurring in other parts of the circulatory system may likewise happen in the vessels of the brain. In the case of Caroline D——, a girl of eighteen, who was in the hospital last year,[1] the brachial artery was blocked by what the patient's other symptoms showed was probably a thrombus in a vessel affected with syphilitic thickening. Under the influence of mercury and iodide (they were both employed) the circulation became restored, so that not only did the radial pulse become perfectly evident to the touch, but sphygmographic tracings of it were able to be taken in a situation in which during some weeks no sign of pulsation had been perceptible. The position of the artery in that instance offered a most valuable opportunity for observation, such as is necessarily wanting when the arterial change affects, as it does with marked preference, the vessels at the base of the brain.

[1] Vide Clinical Society's Transactions, vol. xi., p. 205.

ROYAL MEDICAL BENEVOLENT FUND SOCIETY OF IRELAND.—The annual meeting of this estimable society was held on Monday last in the library of the Royal College of Surgeons in Ireland. The chairman drew attention to a circumstance which he considered a disgrace to the medical profession—viz., that of 2500 members of the profession in Ireland not one-fourth subscribed to the Society, so that deserving cases had to be refused, not because they were ineligible, but because there were more eligible cases brought forward. The money awarded this year is £1344, and the total number of claimants 99, fourteen of whom are new cases, including two medical men. Among the contributions it is gratifying to learn that a sum of upwards of £32 was subscribed by medical students.

Croonian Lectures
ON
SOME APPLICATIONS OF PHYSICS TO MEDICINE.

Delivered at the Royal College of Physicians of London, March 1879,

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LECTURE I.—PART II.

ON FLUID FRICTION AND CAPILLARITY.

WHEN fluid, instead of issuing from a merely linear orifice, has to pass through tubes of greater length, the force of friction comes into play. It has been found experimentally that if the tube be forty-eight times its diameter in length, the discharge is ·63 of that given by the Torricellian theory. In capillary tubes, moreover, according to the experiments of Poisseuille, the velocity of the discharge varies directly as the pressure, and not as its square root. Poisseuille also found that the discharge varies as the fourth power, not as the square of the diameter of the tube.

The formula may be concisely stated—

$$Q = A \times \frac{p\,d^4}{l}.$$

p = pressure per square inch.
Q = quantity discharged in given time.
A = a constant depending (1) on the units of the time and length, (2) on the liquid used, and (3) very materially on temperature.
l = length, and d = diameter of capillary tube.

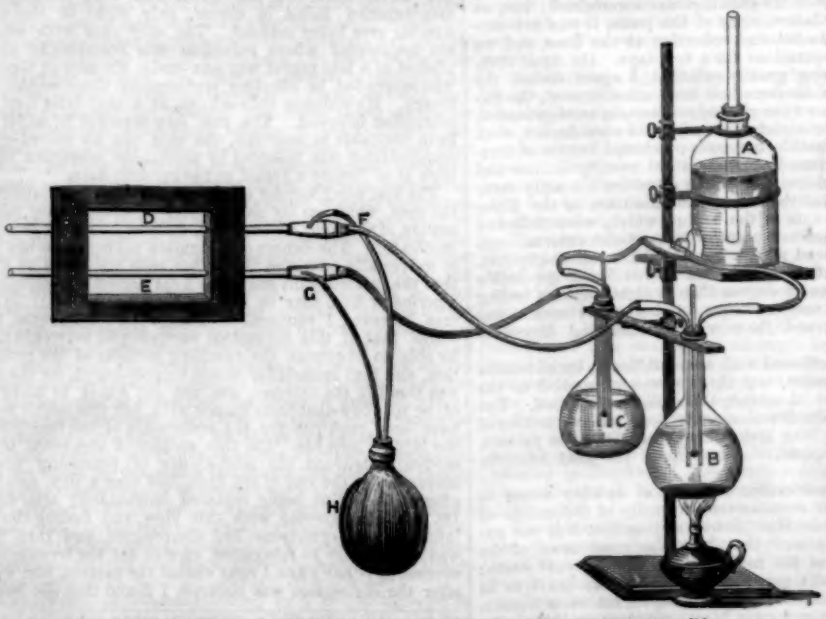
Under heading A(2) may be generally named the viscosity of the fluid employed, and under A(3) the alteration of efflux from temperature. Both these are given for water, saline solutions, and a colloid such as turpentine in the appended table, from the experiments of Girard quoted by Dr. Haughton.

	Temp.	Time of efflux.
Water	32°	1036"
	140°	306"
,, containing sugar ⅓	37°	1947"
	140°	548"
,, containing sodium chloride ⅓	37°	1337"
	140°	443"
,, containing sodium sulphate ⅓	68°	872"
	149°	371"
,, containing potassium nitrate	32°	681"
	140°	310"
Oil of turpentine	66°	13315"
	127°	830"

It may here be noted that as the efflux in a given time increases greatly with increased heat, so the height to which a column of fluid rises against gravity in a capillary tube diminishes. Water, which rises the most of all fluids, owing to the force of capillarity, if standing in a given tube at a height of 30·7 mm. at the temperature of 0° C., falls to 26 mm. at that of 80° C.

Now, it can hardly be doubted that these facts, which have hitherto been limited to physical observers, and only very imperfectly appreciated even by them, must have important bearing on many physiological problems. They evidently touch closely on the great distinction between colloids and crystalloids. They indicate a very sensible difference in permeability between the highly fibrinated blood of health and of plethoric states, and the watery fluid of chlorosis and leucocythæmia. Lastly, it is clear that if, as proves to be the case from recent experiments, water passes five times as fast at 100° C. through a capillary tube as it does at 0° C., the possible differences of temperature in the human body between subnormal states and the greatly raised readings of hyperpyrexia, may materially alter the coefficient of capillarity in the blood, and that the dicrotic pulse of typhus may not only be due to altered conditions of the propelling machinery *à tergo*, but to sensibly diminished tension and resistance *à fronte*.

Speaking generally, we seem to have in capillary phenomena and their modification by heat a lower link in the chain of molecular forces of physiological importance than those of endosmose and diffusion. We are thus able to see, in circumstances purely physical, the key to higher vital and more complex actions. It is so important to substantiate, and, as it were, to drive home, theoretical speculation of this character by objective experiments, that I will venture, Mr. President, with your permission, to attempt a bold, I may say an audacious, demonstration, which has for its purpose to throw on the screen the visible results of the influence of temperature on capillary transmission.



A, Mariotte's bottle. B, C, Similar beakers. D, E, Capillary tubes forming lantern slide. F, G, H, Apparatus for introducing small air-bubbles into the current.

Water was allowed to flow from a Mariotte's bottle (A) *into two similar beakers, one of which* (C) *was at the ordinary temperature, while the other* (B) *was raised to the boiling-point. The two streams, under similar pressure, but differing in heat alone, were allowed to flow along two similar capillary tubes* (D, E), *of 1·25 mm. bore, placed in the field of an oxyhydrogen lantern. To indicate the different speed of the two streams, small bubbles of air were introduced into the main current at* G *and* F, *from an india-rubber bottle* (H). *The rapidity of transmission of the index-bubbles in the cold*

current passing through E *was such that they could be individually identified; whereas the hot stream moved so much faster than the former that the bubble images were fused into a continuous and indistinguishable line on the screen.*

CASE OF COMPLETE DISLOCATION OF THE HEAD OF THE RADIUS FORWARDS,

SUCCESSFULLY REDUCED TWENTY-FOUR DAYS AFTER ITS OCCURRENCE.

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THE following case is brought forward as an example of a comparatively rare injury, and of a positively excellent result obtained under peculiarly unfavourable circumstances.

A. B——, aged five, when running at school, fell over a form on March 22nd, 1878. On her return home she complained of pain in her left elbow, but no attention was paid to it until the following Sunday, when, on her arm being suddenly seized by one of her parents, she cried loudly, and seemed to be much hurt. No advice was sought until the 29th March, when my friend Dr. James Brander was called in. He found great inflammatory swelling of the left elbow-joint, with some œdema of the hand and forearm. The inflammatory symptoms were so marked that, although he felt satisfied, from the very evident malposition of the limb, that the patient was the subject of severe injury of the joint, he did not feel justified in manipulating the parts so as to ascertain the exact nature of the case. Soothing applications were prescribed, and strict rest enjoined. The swelling of the tissues in the neighbourhood of the joint persisted, the skin became brawny-red, and the œdema of the hand remained undiminished. On April 8th he kindly requested me to visit the child in consultation with him, when the presence of the luxation was ascertained; but, on account of the inflamed state of the parts, it was not considered prudent to attempt reduction at the time, and we agreed to delay operations for a few days. On April 17th, inflammation having greatly subsided, I again visited the child, and, after chloroform had been administered, the following appearances were elicited:—Forearm semi-pronated, midway between complete extension and semi-flexion, with well-marked inclination outwards; external border of forearm slightly shortened; an unnatural vacuity behind and below the external condyle in the situation normally occupied by the head of the radius; an alteration in the direction of the long axis of the radius, which, when followed with the fingers, led to a point in front of the external condyle, where the head of the bone could be distinctly felt. On attempting to flex the forearm it was found impossible to bend it to a greater degree than a right angle, a feeling of locking being very manifest. Complete extension was readily achieved, and there was an abnormal degree of lateral motion.

Reduction was effected with some difficulty by extension and counter-extension, and thumb-pressure applied to the head of the radius. A rectangular splint was applied. Ten days afterwards Dr. Brander commenced passive motion of the joint; and on May 17th, when I next saw the patient, recovery was complete, the motions of the joint being in every way perfect.

Remarks.—Considerable diversity of opinion seems to exist regarding the commonness or rarity of dislocation of the radius forwards, Hutchinson[1] stating that it is not uncommon, and Erichsen[2] that it is the most usual of the three dislocations of the radius alone; while Boyer[3] wrote: "Mais on ne connaît pas d'observation bien authentique de la luxation de l'extrémité supérieure de cet os en devant. ..... Nous doutons que cette luxation puisse avoir lieu sans une complication de fracture. ..... On ne peut donc, dans l'état présent de nos connaissances, admettre une luxation de l'extrémité supérieure du radius en devant." Boyer's statement that this dislocation cannot occur without fracture has been completely refuted, but the paucity of cases recorded by writers of surgical works would lead to the belief that it is rare. Sir Astley Cooper[4] only met with it six times. Malgaigne[5] met with three uncomplicated cases. Hamilton[6] saw it nine times. Chelius,[7] Bransby Cooper,[8] and Pirrie[9] have each placed two cases upon record. Many other isolated examples have been recorded, but I only cite the names of a few surgeons who have had great experience in this department of surgery as indicative of the comparative rarity of the lesion under notice. Apart from its frequency or infrequency the case possesses features of interest. The symptoms presented by it were those generally described, but the only one to which I would direct attention is the oblique inclination of the forearm outwards, which, as I have already stated, was well marked, and which was certainly most striking. To Malgaigne must be ascribed the credit of first describing it, and he speaks of it as "un phénomène essentiel," notwithstanding which, with the exception of Hamilton, Lane,[10] and Nélaton[11] (who gives "l'inclinaison de l'avant-bras en dehors" as one of the diagnostic signs between complete and incomplete dislocation forwards, it seems to have escaped the observation of other writers on the subject), some of whom give figures representing the appearance accurately enough, and who, while detailing all the other symptoms at length, yet omit to even notice the one to which Malgaigne has so forcibly alluded. In the case now under notice it was the first symptom observed, and one of the most telling of any of the signs elicited; it therefore seems to be well worthy of note, and deserving of more attention that it has yet received.

The next point of interest is the reduction of the luxation at so distant a period from its occurrence as twenty-four days. The difficulty of reducing even a recent dislocation of the kind is universally acknowledged, and has been well put by Nélaton in the following sentence, taken from his work already mentioned:—"Pour la luxation complète, la difficulté de la réduction, déjà signalée par Hippocrate, semble prouvée par la proportion des pièces pathologiques recueillies, comparée aux faits observés sur le vivant." Sir Astley Cooper failed in two cases, and Hamilton in one, on the seventh day, and in Malgaigne's collection of twenty-five cases, excluding six which had been unrecognised, manipulation failed in eleven, only eight of the entire number ever being reduced. The only case with which I am acquainted where reduction was successfully accomplished at a late period was one under the care of Gosset,[12] who succeeded in effecting replacement three weeks after injury. Hutchinson reduced one at a still later date, but reluxation followed. The case now recorded is, so far as I have been able to ascertain, the only one on record where manipulation was followed by permanent reposition of the bone at so distant a period as twenty-four days.

The last point worthy of mention is the after-treatment of the case, which, so far as the time of commencing passive motion of the joint is concerned, differed from that generally inculcated. The danger of reluxation taking place has been so universally admitted that it has been laid down as a rule that the injured joint should be kept perfectly immobile for a period of from four to five weeks (Chelius, &c.) In this case, however, I ventured to take a different course, for I feared that if this injunction were obeyed we would never be able to overcome the resulting stiffness of the articulation, and that immobility would be permanent, for the child was timid in the extreme, and not one likely to make use of, or to allow that interference with, her arm which would have been requisite for the restoration of the functions of the injured member. On this account I suggested to her medical attendant the advisability of practising passive movement at the end of ten days, first once a day, and then oftener, the splint being replaced immediately afterwards. Dr. Brander, agreeing with this view, and finding that all inflammatory symptoms had disappeared, and that there was no tendency to reluxation, carried out the treatment so successfully that when I next visited the patient, four weeks after the dislocation was reduced, I found that she had re-

[1] Med. Times and Gazette, vol. i. 1866, p. 410.
[2] Science and Art of Surgery, 7th ed., vol. i., p. 486.
[3] Traité des Maladies Chirurgicales, 2nde ed., tom. iv., p. 230.
[4] Dislocations and Fractures (edited by Bransby Cooper), p. 452 et seq.
[5] Traité des Fractures et des Luxations, tom. ii., p. 655.
[6] A Treatise on Fractures and Dislocations, 4th ed., p. 579.
[7] Chelius's Surgery (edited by South), vol. i., p. 791.
[8] Loc. cit., p. 457.
[9] Principles and Practice of Surgery, 3rd ed., p. 895.
[10] Cooper's Surgical Dictionary, 8th ed., vol. i., p. 640.
[11] Pathologie Chirurgicale, tom. iii., p. 134.
[12] Cooper, loc. cit., p. 458.

gained the full use of the joint, and that she could move it as easily and as perfectly as she did its fellow—a result which far exceeded my fondest anticipations, and which certainly justified the departure from the hard and fast line drawn by surgical authorities when dealing with the after-treatment of dislocation of the head of the radius forwards.

Aberdeen.

THE CLINICAL TRACES OF PULMONARY HÆMORRHAGE.

BY REGINALD E. THOMPSON, M.D., F.R.C.P.

IN a paper read during the last session before the Medical and Chirurgical Society, I gave an account of certain peculiar conditions which are frequently to be met with in the lungs of patients who have suffered from severe hæmoptysis. From the resemblance which these hæmorrhagic nodules have to caseous pneumonia and patches of tubercular matter they have been passed over and misinterpreted.

Briefly to mention the chief results obtained from the inspection of many lungs in cases where there has been a history of hæmoptysis of considerable amount, it will be sufficient to say that the conclusions deduced are as follows:—Blood may be extravasated, as everyone knows, either from pulmonary capillaries or a large pulmonary vessel; if the blood be derived from the rupture of a small vessel into the pulmonary tissue, the traces of hæmorrhage will be shown by the presence of black pigment in the locality, or by a small patch of hard white matter mottled with black pigment; but if blood has been poured out in any quantity there is considerable risk that some portion may be driven back into the lung by the force of inspiration, to be landed in and impacted into the lobules, either by inspiration only in the case of the blood being driven into the apex, or by inspiration and gravitation combined, when the blood descends to the base of the lung; the traces of hæmorrhage are then seen in the presence of peculiar hard nodules, varying in colour from red and yellow to an ivory white, and varying in size from a pin's-head to a walnut, but usually being of the size of a little finger-nail, and found in peculiar localities in the apex, the anterior inferior border, and anterior axillary portion of the lung. These nodules may remain unaltered for months, and even years, after the hæmorrhage has taken place, leading to thickening of the surrounding lobular tissue, and to pleurisy if they are near the surface; but under certain secondary processes they may liquefy, and clear out by expectoration, leaving thus corresponding cavities in the lungs. In these peculiar conditions there is distinct evidence of the inspiratory force acting on the lungs, and leaving its marks behind it in an unmistakable manner; another example of the auto-infective power of this force, in addition to those which were brought forward by me in a recent paper on this subject in THE LANCET. There is nothing very startling in the notion that the atmospheric pressure (fifteen pounds to the square inch) would, if any blood were blocking a passage through the bronchial tubes, drive it back into the lungs, nor do the results observed differ materially from the experiments made by the injection of blood into the lungs of animals, experiments which, however, are strongly opposed to the notions of Niemeyer on this subject. No doubt the patches described by Niemeyer and his followers as due to caseous pneumonia are the same as those just described, but they are simply impacted, decolourised, contracted clots of blood.

The point to which I would direct attention in the present contribution is the support which is obtained from the consideration of the clinical traces of hæmorrhage; the clinical symptoms, the physical signs, appear simple and intelligible when looked at in the light afforded by pathology.

The number of patients suffering from recent hæmoptysis who have come under my notice is now very large, and in a great proportion of these cases the physical signs, which are peculiar, are uniform in character.

The first stage of hæmorrhage is the presence of blood in the alveoli, indicated by a peculiar crepitant râle heard over the part affected. It might, perhaps, be doubted whether blood could give such a distinctive sound that its presence could be established with any degree of certainty; but this notion is confirmed by the expressed opinion of Laennec, who taught that the presence of blood did give a characteristic sign, which he describes in the following words:—"Un râle crepitant qui existe aux environs du point où la respiration ne s'entend pas, et qui indique la legère infiltration sanguine que nous avons decrite ci-dessus." He goes on to describe the peculiar characters of the sound, which is more fluid, the bubbling being of a larger quality than in the case of mucous râles. There can be little doubt, from his description, that he considered the sounds of blood in the alveoli as unique; and certainly my own experience would strongly support this opinion.

The râle is heard at the end of inspiration, and is exaggerated by deep breathing. The regions in which it may be generally detected are worthy of note. Under the clavicles near the root of the lung, or in the supra-scapular fossa near the spine,—these are the regions in which this sound is to be heard if the hæmorrhage occur in an early stage of disease; but if the lungs be much affected, then the inferior border of the lung must be examined, and the anterior axillary portion in the region of the nipple.

It is not right, however, to suppose that these regions indicate the source of hæmorrhage, although it is not infrequent to find patients who tell you that their medical attendant told them from which lung the blood came. All that can be decided, on the detection of this sound, is that blood is present there, but it may have been introduced by insufflation, or by insufflation and gravitation. This crepitant sound may remain fluid for a long time, and I have often listened to it week after week, even sometimes for two or three months.

The following cases may be given in illustration of this statement:—

Albert W——, seventeen years of age, had been attacked by hæmoptysis to the extent of a pint and a half on the 14th of July. There was no previous history of disease, and on examining the lungs I found the peculiar crepitant râle of blood in the right supra-scapular fossa. This was heard on Aug. 6th, three weeks after the hæmoptysis.

Martin M——, twenty-two years of age, who had been in the hospital and had been attacked several times with hæmoptysis, was examined by me in June last. I then found the peculiar spongy crepitant râle under the right clavicle, and some also behind at the lower angle of the scapula. This was one month after the last attack of blood-spitting.

Alfred H——, aged thirty, without any history of previous cough, was attacked with hæmoptysis after a rapid walk. No history of hereditary predisposition could be obtained. He was examined by me three months after this date. The crepitation of blood was found at the right supra-scapular fossa. This is an extreme, but by no means an isolated, example. The length of duration depends upon the quantity inhaled, and also, it may be presumed, on the condition of the patient.

The next stage is that of consolidation, the sounds heard being no longer those of fluid blood, but of lung-tissue occupied by solidified matter. This condition is due to the absorption of the blood in the outlying alveoli, while that in the centre remains, becoming consolidated and incapable of removal. I must again refer to Laennec to show that he recognised this condition, although he misinterprets the pathological condition. In continuation of his previous description he goes on to say: "Ce râle crepitant a toujours lieu au debut de la maladie; plus tard il cesse souvent de se faire entendre." The moist crepitant râle becomes more viscid and scanty; it gives way finally to a sticky râle, audible only after cough and deep inspiration; alveolar expansion is diminished, the breath-sounds becoming silent, the voice-sounds higher in pitch, and percussion giving a duller note.

The third stage—that of contraction—is marked more by the external than the internal physical signs. This contraction is due to hardening of the consolidation and retraction. This condition of the clot is sometimes seen in a very marked way at the post-mortem table, where the lung is found much puckered at places corresponding to these nodules. This appears to me a satisfactory explanation of that marked retraction of chest-wall which has been observed by others to follow profuse attacks of hæmoptysis, and which is certainly not explained by the theories of Niemeyer.

The illustration of this point I will give the following notes from my case-book.

One of the most remarkable cases is that of a young man who has been in the hospital occasionally since 1875, and has been also out-patient, generally coming for advice after attacks of hæmoptysis, to which he is subject. He first came under my notice in March, 1877, and then gave a history of profuse hæmoptysis, but no inherited disease, nor history of previous cough. I examined him carefully, but could only detect want of expansion, and some dulness of percussion under the right clavicle; he had symptoms of hypertrophy of the heart, for which I could obtain then no reason, although I questioned him closely. He again came for advice in February of the present year, with an account of other attacks of severe hæmoptysis. This time I elicited the fact that he was a runner, and that the blood-spitting had occurred after racing, and after the exertion of lifting two hundredweight. When examined last he was losing flesh, and there was considerable flattening under both clavicles, chiefly under the left.

Other cases of this character have come under observation in which the blood-spitting has been the initial symptom, and has been the herald of a series of other symptoms, dyspnœa, emaciation, closely resembling the course of ordinary phthisis.

A tall, thin man presented himself in January last, with the following history. He had been in good health until two years and nine months before, when after running up a flight of stairs he threw up a great many mouthfuls of blood. Cough followed this after an interval of nine months. Again, five months before I saw him, when hurrying along to the Victoria Station, he spat up three quarts of blood. When I came to examine his chest, I found considerable flattening, chiefly of the left side, and the physical signs were those of scattered and localised crepitation, and an emphysematous condition between these patches, and in the neighbourhood.

There is another case under my care, a bricklayer, who while at work has been seized from time to time with severe hæmoptysis, and has been brought into the hospital spitting blood in large quantities. This case I have now watched for two years. When he was first attacked with hæmorrhage, although I examined him very carefully I could only find the crepitant râle of blood under the right clavicle. For some time he continued at work, occasionally spitting blood, but within the last six months he has been losing flesh, suffers now from dyspnœa and cough, and when I last saw him I found signs of softening at both apices, with considerable retraction and flattening of the chest.[1]

The conditions which are to be noted in these cases and similar ones are exactly the converse of those observed in ordinary cases of phthisis. If authorities are consulted as to the initiatory signs and the signs of the progressive stages of phthisis, it will be found that there is a general agreement that the sounds indicate a progression from a substance to a fluid, with a corresponding aggravation of the constitutional symptoms; in these cases, however, there is this remarkable difference, that the sounds indicate a gradual hardening of a fluid, the sounds being at first of a liquid character, and afterwards indicating a hard substance. In cases which are complicated by an advanced condition of phthisis, hæmoptysis results frequently in aggravation of the dyspnœa and subsequent emaciation from the occupation of the working alveoli by blood; this is sufficient to produce rapidly fatal results without time being given for the blood to harden and lose its colour. There is, however, a remarkable specimen, which I have recently put up in the hospital museum, showing the upper part of a lung excavated by a large cavity in which there are two aneurisms, the rest of the lung being occupied by white curdy material, which is in great measure altered blood.

If these observations are confirmed by others, the idea that blood produces phthisis by setting up a caseous pneumonia must be discarded, and from a review of the clinical signs which I have here given as those which are frequently found in cases of hæmoptysis, I think it is apparent that they cannot be interpreted with that notion in view, as they differ very materially from those that would result from a caseous pneumonia. If, however, the simple theory be adopted that blood is drawn back into the alveoli and there hardens and contracts, in a condition not very dissimilar to that of embolic clots in the lungs, the clinical signs are readily interpreted, and the relation of blood-spitting to subsequent emaciation and pulmonary disease becomes very simple and intelligible.

[1] Since this was written (last year) this patient has died; and at the examination, which I made myself, the condition of the lungs fully bore out the diagnosis made during his lifetime.

CASE OF RAPIDLY FATAL SEPTICÆMIA DUE TO A WHITLOW.

BY T. W. M'DOWALL, M.D.,
MEDICAL SUPERINTENDENT OF THE NORTHUMBERLAND COUNTY ASYLUM, MORPETH.

I AM tempted to place this case on record because it presents two features of special interest: first, the apparently trivial origin of the blood-poisoning; and, secondly, the severity of the symptoms and the rapidly fatal termination.

The patient, E. C——, was admitted to this asylum in May, 1863, at which time she was fifty-five years of age. She was then in a state of mania, but continued so only for about a fortnight. She soon settled down, and became an industrious, quiet, and well-behaved woman, though she was sometimes transiently excited and abusive, using abominable language indicative of sexual delusions. During the fifteen years she lived in the asylum she enjoyed excellent health, and immediately before the beginning of her fatal illness was in remarkably good bodily condition for a woman aged seventy years.

On the 13th, 14th, and 15th of December last she complained to the nurse of being "out of sorts," but she would not at first see a doctor, as she declared that she would soon be all right. She did not take her food with her usual appetite, was inclined to be sick, had slight headache, but she continued at her work, and was, to all appearance, only suffering from slight constitutional disturbance due to a small whitlow which had begun to form in the right thumb. During these three days she had tea &c. in the way of food, and the thumb was diligently poulticed.

Dec. 16th.—Although she did not complain to the night nurse, she must have become much worse during the night, for she was so ill when she got out of bed, shortly after 6 o'clock, that my colleague was summoned to see her. She said that, in spite of having had plenty of bedclothes, she had been unable to sleep from a feeling of cold. She had also been purged twice. When seen by the assistant medical officer she was suffering from a severe rigor. She was ordered some brandy and hot water &c., which made her, she said, feel more comfortable, but did not otherwise do any good. At 10 o'clock A.M. she was in a very prostrate state. The tongue was so abominably furred, and the mouth so clammy, that she could scarcely be understood when she spoke. The face was very pale and pinched; there was slight general tremor, but the skin was not cold. She lay on her right side with her face to the wall, quite conscious, but so ill that she did not care to be disturbed in any way. When asked if she suffered pain, she vaguely indicated her head or chest, but said nothing. The pulse was small, weak, and rapid. Thirst was urgent. As it was now quite evident that some very serious mischief was developing, she was placed in charge of a special nurse. No active treatment was adopted. Warm milk was given as often as she would take it, and the poulticing was continued. At 2 P.M. her condition was worse. She had been purged several times, the evacuations being thin, pale, and very offensive. The pulse was 150, small, and irregular; respiration 40, and shallow; temperature in the axilla 103°. Delirium now set in, and was almost constant, though she could easily be roused to consciousness by being addressed. Sometimes she struggled to get out of bed, saying that she must put on her clothes. When free from delirium she lay, as already described, on her right side, quite conscious and able to answer questions, but too ill to care to be disturbed. At 6, and again at 11 o'clock, it was noted that her general condition was gradually becoming more feeble, and that she had been purged several times during the afternoon, the evacuations continuing to be very fetid.

17th.—About 1 o'clock in the morning her delirium became more violent; she was very restless, and constantly attempting to get out of bed. Collapse now set in, and she died in half an hour.

A post-mortem examination was made thirty-four hours after death. The following is an abstract of the notes:—

External appearances: The body is fairly well nourished and free from all marks of injury. Hypostasis is well marked in dependent parts, and there are livid patches, about the size of a florin, on the skin of the thorax and abdomen. The skin of the tip and inside of the right thumb is livid, but not gangrenous. Post-mortem rigidity is well marked in both upper and lower limbs.—Head: The skull-cap is densely adherent to the dura mater in the fronto-parietal region. Beyond general atheroma of the arteries and some venous congestion of the pia mater, there is nothing calling for special remark.—Heart: The pericardium contains about an ounce of clear serum. Valves competent. All the cavities contain fibrinous clots partially decolourised. The clots are larger and firmer on the right side of the heart. —Lungs: Right adherent posteriorly by old fibrous bands; otherwise normal. Left contains two cicatrices at the apex, indicating the position of tubercular deposits, which have disappeared.—Spleen a little soft; otherwise normal.—Liver normal. The gall-bladder contains many calculi, and a small quantity of almost colourless bile.—Kidneys: Right slightly congested throughout, and the capsule generally adherent. Left the same, and contains a few small cysts.—Stomach contains about four ounces of slightly bilious fluid, mixed with particles of coagulated milk. The surface is free from all congestion; indeed it appears somewhat paler than usual.—Intestines contain nothing but milk in process of digestion. Though examined from end to end, no trace of congestion or ulceration is found.

Remarks.—This case stands quite by itself in my experience, and I confess to having been in some difficulty in forming my diagnosis. During the last few days I have consulted articles on septicæmia in such works as I had access to, but without finding any similar record. That it is one of blood-poisoning there can be no doubt, I think. In describing the symptoms of septicæmia, Bryant quotes from Simon as follows:—"If the wound become the seat of some large textural disorganisation, with consequent soakage of putrefying material, more marked signs of *blood pollution* may be expected to mix with or supersede those of common inflammatory fever; the patient's general state will then incline to be one of depression and apathy; his tongue will be more than commonly foul, and fetid diarrhœa will probably exist; or if perchance during the local process it happens (as is especially apt to be the case where cancellous bone-structure is affected) that pus passes up a vein into the general stream of blood, the patient's improvement is abruptly cut short by the *severe recurrent rigors and sweating of pyæmia*, accompanied by local signs of secondary suppuration in parts to which the pus in conveyed."[1] He also says:—"Confirmed blood-poisoning therefore is characterised not only by all the symptoms of inflammatory fever, but by severe rigors breaking in upon the febrile symptoms, by sudden and marked variations of temperature, by profuse sweats and great depression of the patient's powers; and when these symptoms occur in the course of an attack of inflammatory fever, severe blood-poisoning is certainly indicated, the gravity of the attack being measured by the intensity of the symptoms."[2] "In feebler patients, who have no resisting power against disease, it is possible that even these pathological conditions [pneumonia in one or other of its stages] may not be found; life being as it were suddenly destroyed in the first onset of the blood-poisoning."[3] "The violence of the attack does not depend upon the severity or size of the wound; for a trifling wound is at times followed by urgent symptoms; while a severe local injury may be followed by but few, if any, complications. Indeed, some of the severest cases of blood-poisoning are found in those in whom there is no wound."

As bearing on this case Dr. Bristowe's remarks are worth reproducing: "Pyæmia is generally an acute and quickly fatal disease; and when this is its character pyæmic deposits may almost invariably be found. The deposits, however, are not generally related numerically or otherwise to the severity of the case; and cases are sometimes observed which, judging from the symptoms during life and from other evidence, are truly cases of pyæmia, yet in which no pyæmic deposits are found."[4]

Concerning those liable to attacks of pyæmia, Dr. Bristowe remarks: "It may be confidently asserted that the vast majority of pyæmic patients have not been suffering from chronic visceral diseases; that but few of those attacked are recovering from acute diseases; and that many, very many, victims of pyæmia have enjoyed the best of health up to the moment of the accident or the operation or the disease which has exposed them to the danger of pyæmia; and that even in many cases the wound (if wound there be) has been progressing favourably up to within a few days of the sudden onset of pyæmic symptoms."[5] As to its duration, he says: "The disease is generally very rapid in its course. Occasionally its duration is limited to three or four days; more commonly it lasts from six to eight days, and it may be for a fortnight."[6]

I have quoted enough to show that the case now under consideration was a genuine case of pyæmia or blood-poisoning. If some symptoms were wanting, this was due to the fact that the disease ran such a rapidly fatal course that there was no time for their development.

In conclusion, such a case might present great difficulties in a medico-legal way. Suppose it the subject of inquiry, no history to be obtained, and a medical man asked to ascertain the cause of death from a post-mortem examination—what could he certify?

[1] Bryant's Practice of Surgery, p. 54. [2] Ib., p. 54. [3] Ib., p. 60. [4] Article "Pyæmia," Reynolds's System of Medicine, vol. i., p. 209. [5] Ibid., pp. 211, 212. [6] Ibid., p. 217.

ON BLOOD-CLOTTING IN THE VESSELS.[1]

BY AUGUSTUS J. PEPPER, M.S., F.R.C.S.

THERE is no more intricate problem awaiting solution at the hands of the clinical and pathological investigator than that of clotting of the blood in the vessels during life. Both as to the causes of the phenomenon and the subsequent changes, the most discrepant opinions have been entertained; each observer founding his own particular view upon some supposed facts met with in the history of this morbid state—facts not unfrequently mistaken in themselves, and inferences therefrom equally erroneous. Now we cannot be so very much surprised at this when we call to mind the many explanations that have been given by the most painstaking and competent authorities of the why and wherefore of coagulation of the blood removed from the body—e.g., the now discarded theories, firstly, of simple change of state of fibrin existing as such in the blood, and secondly, that of Dr. B. W. Richardson, who ascribed it to the escape of ammonia.

Before discussing the subject matter of my paper, I may perhaps be allowed to make a few remarks on the present state of our knowledge concerning the causes of coagulation of the blood drawn from the vessels. This is due to the interaction of three bodies—fibrinoplastin, fibrinogen, and a ferment, resulting in the combination of the two former; that is to say, fibrin which does not exist in the fluid blood comes to be formed under certain ascertainable conditions as the latter becomes solid. There is, so to speak, a constant antagonism between two sets of influences which tend in opposite directions—between those that favour and those that retard or prevent coagulation. Among the former are—1, rapid motion, as in whipping, or, in other words, multiplication of points of contact; 2, exposure to not-living matter. Among the latter we have—1, the addition of a third of the bulk of a saturated solution of some neutral salt; 2, a temperature of about 32° F.; 3, moderate heat; 4, the abstraction of hæmoglobin; 5, the absence of a neutral salt, whose presence, according to Schmidt, is essential to coagulation.

Now blood, whilst in the vessels, is known to clot more easily when the current is slowed, just the reverse of what is found in shed blood; but this is only an apparent anomaly, for when we consider that slowing of the blood-current means a diminution in the nutrition of the coats of the vessel, and that this diminution of nutrition brings it to a state of lower vitality, the question of slowness or rapidity of flow is resolved into that of contact with foreign matter.

As to the so-called ferment—whether it be fluid, or solid in the shape of germs visible or invisible—few can doubt the conditions under which what are termed the consequences of its action are brought about in the living body, and none can

[1] Paper read before the Medical Society of St. Mary's Hospital, Feb. 5th, 1879.

conscientiously deny the advisability of doing all that lies in our power to counteract its influence, which may be so potent for evil. And it is here, I think, that the antiseptic treatment of wounds shows itself to manifest advantage, for when decomposition of the discharges is allowed to take place unchecked, how much more likely are we to get thrombosis extending beyond the immediate seat of injury, how much more likely in such cases to get rapid softening of the clot, and, as a natural consequence, detachment of emboli rife with mischief, by reason of their mechanical action, and still more so because they are saturated with septic matter. It is often a question of pyæmia or not—of life or death to the patient.

The two prominent features of thrombosis are: 1. Its causation. 2. The fate of the clot.

To gain some clue to an answer to the question, Why does the blood coagulate in the vessels? let us consider the diseased states which are not unfrequently complicated with the untoward event. And firstly, because they will be fresh in the minds of many of you, I will give you the fatal cases that happened in our hospital during the past year. There were four of them. The index of the pathological reports runs practically as follows:—

No. 1. Female, aged thirty-eight.—Phthisis; tubercular ulceration of intestines; perforation of cæcum; peri-cæcal abscess; thrombosis of right common and external iliacs and femoral veins.

No. 2. Female, aged forty-six.—Fracture of ribs and pelvis; localised pleurisy; decolorised granular clot in right ventricle; embolism and subsequent thrombosis of pulmonary artery.

No. 3. Female, aged forty-three.—Primary thrombosis of iliac, femoral, and popliteal arteries and veins; gangrene of leg; bedsore; recent infarction in liver.

No. 4. Female, aged sixty-three.—Cancer of cæcum; perforation; acute peritonitis; phthisis; thrombosis of left femoral and popliteal arteries and veins; gangrene of leg.

The third case, since the patient was apparently a healthy woman until the onset of the plugging, seems to point to the condition of the walls of the vessels as the immediate cause; and the microscopical appearance of the internal coat of the arteries gave weight to that view, even if it did not establish its truth.

In the other three cases, you note that in two of them there was a combination of circumstances likely to lead to a vitiated state of blood: in one cancer and phthisis; in another phthisis and ulceration of the bowel, with abscess from perforation; whilst the remaining one falls into the same category, seeing that in it there was sudden diminution of bodily activity through confinement to bed from severe injury.

Amongst those that have come under my own observation are the following:—

Thrombosis of cerebral veins in phthisis and in marasmus; of the basilic and other veins of the arm in septicæmia, from compound fracture of jaw, with cellulitis of forearm; of pulmonary artery, fatal immediately after parturition; of the varicose veins of the lower extremity; of axillary and femoral veins in post-parturient women; of the axillary vein in rheumatic fever; of the brachial artery from bruising. In textbooks you will find, amplifying the list: Plugging of the cerebral arteries in syphilis; capillary thrombosis as the starting-point of cancrum oris, and as the explanation of the multiple openings in carbuncle; not forgetting those cases where coagulation is intentionally brought about, as in the ligation of arteries, and the operation for varicose veins. On analysing the foregoing, we arrive at the conclusion that there are two diseased conditions—one of the bloodvessels, the other of the blood,—which are so frequently seen as marked features in thrombosis that we are driven to accept that a causal relation exists between them. Slowing of the blood-current from weak action of the heart acts as a subsidiary factor.

In the first place, let me explain the different ways by which the blood may become so vitiated that its fluidity can no longer be maintained; and the simplest way of doing this is to make two groups: (*a*) that in which the fibrin factors are increased; and (*b*) that in which excrementitious matter is in excess from defective elimination, as in gout, or abnormal material is introduced from without, as in septicæmia.

The two groups are purely artificial, and are introduced rather for the sake of clearness of demonstration than for clinical accuracy. If it be admitted that the composition of the blood does play a very important part in its own coagulation, there remains for consideration the nature of the changes which directly underlie the phenomenon. The reasoning on this point, since we know of so few facts and still less of their correlation, is to a great extent speculative. Yet although this forbids our drawing any wide conclusions, there is sufficient that is probable to urge to further research and to some extent to indicate the line of action to be taken. Such questions as the following suggest themselves:—Is the chemical composition or constitution of the fibrin factors altered? If so, does this depend on a general physico-chemical change of the constituents of the blood in which they are involved, or is there some definite yet subtle agency at work sufficing to effect the necessary means to the end? And supposing this to be the fact, what is the nature of that agency? Is it an altered mode of life of the white corpuscles by virtue of which they entail in their own changes the coagulation of the blood? We know that on watching the clotting process in liquor sanguinis obtained by subsidence, it is seen to commence by the formation of fine threads of fibrin in connexion with the leucocytes. Or, again, may not the conditions of these leucocytes be one of death rather than life, and that thus they count only as any other foreign matter? By most observers the former hypothesis is deemed the correct one; but Mr. Wharton Jones, one of the greatest of living authorities on the subject, looks upon the amœboid movements as the manifestations only of moribund corpuscles. Lastly, does not the whole question turn on the generation of a ferment, and thus place us on a less equivocal basis by relegating the condition to others of a similar nature tolerably well understood? The fact that coagulation of the blood is more likely to take place in such diseases as pyæmia, septicæmia, and the like, where minute organisms called micrococci have been found, lends weight to such a theory.

Since the above lines were written there has been a case in the hospital of acute necrosis of the clavicle, in a well-nourished girl aged fourteen years, coming on without apparent cause, and this was the sequence of events: acute periostitis and ostitis leading to necrosis, thrombosis of the common femoral vein, disintegration of the clot, embolism, and circumscribed metastatic abscesses in the lung; at no time was there a wound of any kind. This case illustrates two points in pathology: firstly, that the blood-poisoning may be developed without access of air to favour or account for the necessary decompositions—a proof, I think, that the most virulent pyæmia may depend entirely on the infective matter resulting from the inflammatory state; and, secondly, that the change in the blood is sufficient to bring about its coagulation without appreciable disease in the walls of the containing vessel.

(To be concluded.)

NOTES OF MILITARY SURGERY.

BY SURGEON J. LEWTAS, M.B. LOND.,
GUIDES CAVALRY.

A FEW notes of some of the injuries received in the cavalry affair near Futtehabad, Afghanistan, on April 2nd, may perhaps interest some of the readers of THE LANCET. The portion of the Guides Cavalry present on that occasion numbered about two hundred sabres, and our casualties were five killed and twenty-eight wounded.

CASE 1. *Penetrating Gunshot Wound of Frontal Bone.*—The subject of this injury, a Sikh trooper, was hit by a stray bullet before the cavalry came into action. The bullet entered just above and to the right of the root of the nose. At the same time, also, the right eyeball projected prominently forwards, and was painful. He did not lose consciousness, but complained of pain in the head, and especially in the right eye. The eyeball was uninjured, but the conjunctiva was injected, and there was a small quantity of blood between the lids. He thought that the ball had passed out through the right orbit—a not impossible hypothesis, since bullets were coming across from our left, where the enemy were outflanking us. The subsequent history of the case, too, gave support for a while to his idea, for it seemed to indicate but slight injury to the brain. During the first eleven days the only symptoms were diffused headache and drowsiness, while there was dilatation

of the right pupil and ptosis of the right upper eyelid, the two latter symptoms being not impossible results of an injury to the orbit only.

Suddenly, however, on the eleventh day, new symptoms developed themselves—viz., epileptiform convulsions followed by coma. The first fit occurred about midnight on April 13th. This passed off in half an hour, leaving a condition of extreme susceptibility to muscular spasm; so much so that the attempt to give him a drink brought on locking of the jaws, twitching of the facial muscles on the right side, and spasmodic movements of the limbs. About an hour later he had a second fit, and the convulsive stage of this was of such duration, and attended by such exhaustion—his body being bathed in perspiration and his pulse rapid beyond counting—that I resorted to chloroform-inhalation to bring on the stage of coma at once. A subcutaneous injection of one-sixth of a grain of morphia was given to him while under the influence of chloroform, and he then slept for four or five hours. The next day, April 14th, he had a third fit, which was similarly treated, and since then up to the present date, April 23rd, there has been no return. Dilatation of the right pupil and ptosis persist. There is, however, no squint; nor are any of the movements of the eyeball impaired. He is drowsy and somewhat irritable. There is also decided impairment of memory, as he no longer remembers the occurrences of that day, or even that he was wounded. There is still an abundant discharge of yellowish-green pus from the opening in the frontal bone, and there is some prominence of the inner angle of the roof of the right orbit.

Remarks.—The course and symptoms have not, I think, confirmed the opinion of the man himself that the ball escaped by way of the right orbit; the injury to the contents of the latter would have been greater, whereas the protrusion of the eyeball would be sufficiently accounted for by a depression of the roof of the orbit caused by the bullet in its passage backwards. There can, I think, be little doubt that the ball has lodged within the skull, but at what precise spot it is impossible to determine.

CASE 2. *Gunshot Fracture of Great Trochanter of Femur; death on nineteenth day.*—The bullet in this case entered at the outer side of the right thigh, about two inches below the great trochanter, passed upwards and inwards, splintering that projection, and finally lodged superficially over the base of the sacrum, where it pointed. Its position, however, was not so superficial that the bullet could be grasped between the finger and thumb; it gave rise rather to a diffused swelling, in which the exact position of the bullet was uncertain. Hence I did not feel justified in cutting into this prominence, but sent him as he was to the field hospital at Jelalabad, where a few days later the bullet worked towards the surface, and was extracted. The discharge from the track of the bullet was abundant and fetid; syringing the wound twice, and sometimes oftener, daily with carbolic lotion, and a free use of disinfecting powder (M'Dougall's), failed to keep down the fetor. He was further weakened by obstinate diarrhœa, over which treatment of various kinds had little effect. He died on April 20th, nineteen days after receiving the injury.

Remarks.—It is not the time yet to gather up the lessons upon gunshot fracture of the thigh derived from this war. Five cases have now come under my notice, and they have all supported the received canons of military surgery; especially have they shown the advisability of *immediate* amputation in fractures of even the upper third if, as is invariably the case in hill warfare, the patient has to be carried many miles to a permanent hospital, for on arrival at the latter he is so exhausted by the journey, and the limb is so much swollen, that an amputation then performed has most unfavourable results. In saying this I have two cases in particular in my mind, both of them gunshot fractures of the upper half of the femur. One of these was carried from Ali Musjid to Jumrood, about ten miles; the other was carried for more than twelve hours in a dhooly, part of the time in darkness over rocks; and both of them died under the subsequent operation. The case of a man so injured is desperate, and justifies desperate measures: if, under the conditions supposed, his chance of life is increased by immediate operation, then the general rule of deferring all operation until arrival at a field hospital may surely be departed from, and advantage taken of the first halt to amputate the limb. The other plan has been tried, and with melancholy results; this of immediate treatment (under the circumstances mentioned) has not yet had a trial.

CASES 3, 4, 5, and 6 were bayonet-wounds—two of them non-penetrating of the walls of the chest, and which soon got well; the third peculiar from its situation—viz., in the right side of the fauces. The subject of it was leaning over in his saddle to make a cut, and received the bayonet in his mouth. The symptoms were only slight—some pain in swallowing, with slight swelling and tenderness of the neck.

The last case was a more serious one. The bayonet entered about two inches to the left of the navel and penetrated the peritoneum. Acute pain and collapse followed immediately, and some air seemed to have entered with the movements of respiration, for a few hours later the abdomen was tympanitic. Localised peritonitis followed, but the patient is now (April 23rd) convalescent.

CASE 7.—This is worth mention, as showing what terrible injuries a man will survive for a short time. The skull in this case, that of a non-commissioned officer, was cleft transversely across the vertex, the sides of the cleft being separated in the widest part by an eighth of an inch, and the cleft extending from ear to ear. In addition to this, another sabre-cut had raised the parietal portion of the temporal bone from its connexions. Yet this man lived until the fifth day, and never lost consciousness until shortly before death.

A Mirror OF HOSPITAL PRACTICE,

BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tam aliorum, tam propriis collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

GUY'S HOSPITAL.

CASES OF OVARIOTOMY IN WHICH ICE WAS LOCALLY APPLIED TO THE ABDOMEN AFTER THE OPERATION, FOLLOWED BY RECOVERY.

(Under the care of Mr. BRYANT.)

IN the following cases of ovariotomy ice was applied locally to the abdomen for several days after the operation, and the sponges employed were, as is usual in Mr. Bryant's practice, washed in iodine water (two drachms to a pint). In most of the cases it will be seen there was little or no elevation of temperature after the operation, and that in all a good recovery took place. There are good reasons for believing that the favourable results may be attributed to the treatment pursued, and that in the use of ice to the abdomen the surgeon has at his command a powerful means of preventing the elevation of temperature and of controlling it. Mr. Bryant says he thinks it probable this effect is brought about through the influence of the inorganic nerves.

CASE 1. *Ovariotomy; application of ice to the abdomen; recovery; highest temperature 100°.*—Ruth H——, aged twenty-two, was admitted Jan. 24th, 1877. Her general health was not good; had always been weakly. Married; miscarried at three months two years and a half ago; one child born sixteen months since, but died when fourteen months old; another seven months' child was prematurely born three months ago.

Thirteen months previous to the birth of her first child (about two years and a half ago) she noticed that her abdomen began to swell on the right side, but she thought she was pregnant. In thirteen months a child was born, yet the abdominal swelling did not quite disappear, but the swelling was centrally placed. She slowly increased in size up to the time of admission. Her last confinement was prematurely brought on. She lost flesh, and her legs swelled towards night-time. After her last confinement she had menstruated weekly, before that she was quite regular.

On admission there was great distension of abdomen, but more on right side than on left. Thrill on percussion all over tumour, which, however, was lost in the flanks. Tumour was generally soft, except about two inches above and a little to left of umbilicus, where there seemed to be a solid growth. Dulness general, except at flanks and epi-

gastrium. Pain at epigastrium. No dyspnœa. Per vaginam, uterus was freely movable and well behind tumour. No albumen in urine. Ordered quinine and iron mixture three times a day.

On the evening of Jan. 29th she was transferred to Clinical ward. The excitement of being moved caused her to feel faint and queer; she became a little hysterical. Next morning she felt very comfortable; had slept well. Menstruation began on the 27th; still continued. Temperature 97·6°; pulse 91.

On Feb. 7th ovariotomy was performed in usual method. There was an enormous polycystic tumour, with two smaller solid masses. Large incision to above umbilicus necessary. Universal firm adhesions to abdominal parietes; one adhesion to mesentery; good pedicle. Silk sutures were used, and a glass drainage-tube was inserted at lower part of wound. After operation morphia suppository was introduced, and ice applied to abdomen. Abdominal cavity carefully sponged with sponges washed with iodine water. At 5.30 P.M. there had been a little oozing of blood. Complained of great pain in abdomen. Felt sick. At 7.30 P.M. sleeping. At 8.30 P.M. had been vomiting; was in much less pain; very thirsty; in good spirits; had taken about half a pint of iced milk. Skin moist; tongue slightly furred; temperature 99·4°; pulse 136. At 9.30 in less pain. Not able to keep milk down. Temperature 98·6°; pulse 120. 11.15: Temperature 100°; pulse 144. Had been very sick; sickness caused great pain; vomited matter a greenish liquid.

8th.—1.15 A.M.: Temperature 100°; pulse 152, full and strong. Still sick, but felt more comfortable. Urine drawn off. Morphia suppository again introduced. Had been dozing. She passed a fairly quiet night; slept for short intervals, and at 9.30 A.M. she had not vomited since 3.30 A.M. Was very thirsty. Skin moist. Tongue furred. Breathing quietly. In very little pain. Temperature 98·8°; pulse 128. 10 P.M.: Urine drawn off. No sickness; very little pain; no tenderness; free discharge. A morphia suppository was again introduced at 12.30.

She slept well, and was not sick until about 8.30 A.M. next morning. Had not taken much milk. Very little pain; slight abdominal tenderness, but no distension; free serous discharge. Temperature 99·8°; pulse 132; tongue furred; skin moist. Urine drawn off.

10th.—6 A.M.: Urine drawn off. Very comfortable. 10 A.M.: Temperature 100·6°; pulse 140. Has passed a good night; slept well. Feels a little weaker; had not much pain. No sickness. No distension of abdomen; a little tenderness on right side. Discharge not so clear. Menses began about 3 A.M. Skin moist; respiration natural; tongue more furred.

11th.—11 A.M.: No distension of abdomen. Fluid in tube bloodstained; tube removed. Skin moist. At 10.15 P.M. the temperature was 101°; pulse 136. Patient had been in a good deal of pain since tube was withdrawn; had passed water voluntarily. Felt very sleepy. Abdomen a little more tender. Morphia suppository.

She passed a good night, and had but little pain. Next morning she could pass urine voluntarily. Tongue furred down the centre; edges pink; papillæ well marked. Temperature 98·4°.

13th.—11.30 A.M.: Temperature 99·8°; pulse 112. Wound dressed for the first time; it had almost healed, and the sutures were causing no irritation. Around the clamp the discharge was black and offensive. Very little pain. Had not slept well during the night, but felt very comfortable. Was taking chicken and beef broth thickened with sago. At 9 P.M. the bowels were opened, without any pain.

14th.—Passed a good night, and was in no pain. Had a motion this morning. Felt very hungry. Tongue much cleaner. No pain in the abdomen. A little tenderness over the right hypochondrium. Temperature normal. The wound was dressed in the afternoon, and the sutures removed. To have four ounces of brandy and solid food.

On the 15th she had a little diarrhœa, which came on about 3 A.M. She had five liquid, greenish motions in about seven hours. No pain; tongue clean; skin moist. To have an opium enema.

On the 16th she had had two motions during twenty-four hours. Had slept well. Still a little tenderness about the right hypochondriac region. Wound dressed; looked very well; scarcely any discharge, except around the clamp.

19th.—Had a slight recurrence of diarrhœa, checked by an enema of opium. Temperature 99°.

20th.—Slept and ate well; no diarrhœa; tenderness in the right side less; tongue slightly furred; temperature 100°. Clamp almost separated. Wound dressed.

21st.—Clamp came away, leaving a healthy granulating surface. Very comfortable; tongue clean; no pain. Two days later the last stitch was removed. From this time she gradually improved, and on March 17th was discharged, wearing an abdominal belt.

For the notes of this case we are indebted to Mr. C. Knox Shaw.

We shall continue the report next week.

WEST LONDON HOSPITAL.

STRICTURE OF THE URETHRA; PENILE FISTULA; SCROTAL ABSCESS; INTERNAL URETHROTOMY; GOOD RESULT.

(Under the care of Mr. TEEVAN.)

JOSEPH G——, a labourer, forty years old, was admitted into the hospital on Sept. 20th, 1878. From notes taken by Mr. Brown, the house-surgeon, it appeared that in October, 1875, the man had been an in-patient, under Mr. Teevan, for a very tough stricture, involving nearly the whole length of the penile urethra. Internal urethrotomy was performed, and he was discharged quite well and able to pass a large catheter for himself. He regularly introduced the instrument once a week for a year, when he neglected himself and the stricture began to relapse. About a year ago he commenced to experience considerable difficulty in urinating. Two months ago the scrotum and penis began to swell; an abscess formed and burst at the peni-scrotal junction and a fistula was left. The patient was in good health when admitted; the scrotum was indurated and glazed, and pus and urine escaped from the fistula. A small catheter could be passed into the bladder. On account of the character and situation of the stricture Mr. Teevan determined to perform internal urethrotomy again, as a previous experience of the case had taught him that continuous or gradual dilatation would be ineffectual.

On Sept. 24th the man was put under the influence of ether by Mr. T. G. Alderton and the stricture was divided along the floor of the urethra. The same night the temperature rose to 100°, and remained at that point for twenty-four hours. At 10 A.M. Sept. 28th it had fallen to 98·4°. On Sept. 29th Mr. Teevan commenced to pass a large silver catheter every third day, and on Oct. 9th the patient began to draw off all his urine to hasten the closure of the fistula. Two days later he left the hospital. On Oct. 20th he was quite watertight.

Mr. Teevan remarked that the stricture in this instance was of the toughest he had ever had to divide, for a succession of abscesses and an orificial chancre had converted the penile urethra into a tough leathery tube, and unless the patient regularly introduced a catheter at stated intervals the stricture would infallibly relapse, and that very speedily.

IMPASSABLE TRAUMATIC STRICTURE; BOUTONNIERE OPERATION; RECOVERY.

(Under the care of Mr. TEEVAN.)

Richard P——, a labourer, forty-five years old, was admitted into the hospital on Jan. 1st, 1879. From notes taken by Mr. Warrilow, the house-surgeon, it appeared that fourteen months previously the man was getting over a fence, when he slipped, and his perineum struck the top rail with great violence. He bled from the urethra, and was confined to bed for nine days, during which period he expelled large clots of blood, but did not suffer from retention. Gradually his stream of urine became smaller, and he was very frequently troubled to urinate. When admitted, the patient, who was a tall, gaunt man, was in bad health, and of sallow aspect. He had never had gonorrhœa. Could only pass urine in a fine stream. For three weeks he was kept in bed, and Mr. Teevan tried every third day, without success, to pass various instruments through the stricture, which was situated at the bulb.

On Jan. 21st, at 3.30 P.M., the patient was put under the influence of ether by Mr. J. G. Alderton. The Boutonnière operation was performed. A large silver catheter was introduced, and removed as soon as the urine had escaped. 9 P.M.: Temperature 100°.

Jan. 22nd.—10 A.M.: Temperature 101·6°; pulse 120. Patient

slept well; urine passes freely through wound, and some per penem; scrotum and perineum much ecchymosed, but the skin soft and supple. 8 P.M.: Temperature 100·6°; pulse 100.

From this date the temperature gradually fell till the 29th, when it was 98·5°, pulse 82. No. 20 silver catheter was passed on the 24th and 31st, and on February 4th and 13th. After this the patient complained of headache and malaise; and as the local condition was satisfactory he was left alone till February 28th, when an attempt was made to pass a silver catheter into the bladder from the penis, but ineffectually. A large elastic catheter was introduced through the aperture in the perineum, and the urine was drawn off. On March 1st a small filiform bougie was passed into the bladder from the penis, and a silver catheter slid over it. Afterwards a small elastic catheter was introduced and tied in.

March 2nd.—Slight rigor at 1.30 P.M.; temperature 103·6°; pulse 92. Catheter removed 8 P.M.; temperature 99·8°.

From this date a course of gradual dilatation was carried out, and the perineal wound allowed to close. The patient was afterwards taught to introduce an elastic catheter for himself. He left the hospital on April 13th, able to pass No. 14 (Charrière) for himself. He called at the hospital on April 22nd, when he introduced No. 16. He was quite watertight, and able to urinate as well as he ever did in his life.

Mr. Teevan observed that traumatic strictures differed so widely in character from organic ones that they ought to be classed separately by themselves. They formed the bulk of those strictures denominated impassable, usually required the knife, as they were rarely amenable to dilatation, and were marked by their strong and speedy tendency to contract unless instruments were regularly passed at frequent intervals. In the whole range of surgery there was no complaint more troublesome and difficult to treat than an impassable traumatic stricture.

METROPOLITAN FREE HOSPITAL.

TUMOUR OF THE ANTRUM; REMOVAL OF THE LEFT SUPERIOR MAXILLARY BONE FROM A MAN AGED SIXTY-SEVEN; RECOVERY.

(Under the care of Mr. WALSHAM.)

FOR the notes of this case we are indebted to Mr. Byrne, the senior house-surgeon.

John B——, aged sixty-seven, was admitted on March 6th, 1879, complaining of a swelling in the left nostril. He stated that about four months before he first felt pain in the left infra-orbital region, and shortly afterwards experienced a sense of stuffiness in the left side of his nose. The pain had increased in severity up to the time of admission, when it was so great as to cause sleepless nights. He appeared in excellent health, and stated that he had never had an illness in his life, and had always been temperate. His urine contained no albumen. The pain was referred to the front wall of the antrum. He had no discharge from the nose.

On examination, a soft, lobulated, purplish-green growth, readily bleeding when touched, was seen in the left nasal cavity, and could be felt through the posterior nares. The front wall of the antrum was slightly bulged forwards, but there was no protrusion of the eyeball or depression of the hard palate. The growth did not extend through the posterior nares. On submitting a small detached portion to microscopical examination, it was found to have the structure of small round-celled sarcoma.

Looking to the slight bulging of the anterior wall of the antrum and the history of the case, Mr. Walsham came to the conclusion that the growth had its origin in that cavity. He resolved, therefore, to lay open the nose, and to remove the whole of the superior maxillary bone, if the growth were found to proceed from the antrum. This operation seemed justifiable, as, notwithstanding his age, the patient appeared in excellent general health, and, although the growth was probably malignant, there was every reason to hope that the whole of it might be removed.

On March 22nd the cavity of the nose was laid open, and as the growth was found to proceed from the antrum, excision of the superior maxillary bone was performed, and the entire growth removed with it. The incisions through the skin healed by the first intention, and the patient was discharged to a convalescent home on April 7th.

The growth was found to occupy the whole interior of the antrum, and had made its way through the internal wall into the nose, where it filled the greater part of the left nasal cavity. It was found to bulge slightly through the anterior wall of the antrum, but not to encroach upon other parts. From its microscopical characters and rapid growth, Mr. Walsham feared that it would return. Up to the end of April 2nd there were no signs of its recurrence. The parts had gradually filled up with granulations, and the patient was in all respects in good health.

LAMBETH INFIRMARY.

CASES IN WHICH OPIUM HAS BEEN SUDDENLY DISCONTINUED AFTER ITS DAILY USE IN LARGE DOSES FOR YEARS.

(Under the care of Dr. ROBERT H. LLOYD.)

THE following cases will illustrate that it is possible, in many cases, to discontinue suddenly the use of opium without any evil results.

J. H——, aged forty-five, who had had sunstroke whilst in India in 1856, and who has occasionally had epileptiform fits, was in the habit for three or four years of taking an ounce of laudanum every morning, without which he was unable to do any work. He took it at first in twenty-minim doses, to relieve rheumatic pains, but found it such a comfort that he soon increased the dose to one ounce.

On admission he presented all the symptoms of chronic alcoholic poisoning—viz., insomnia, morning sickness, frightful dreams, &c. The patient was placed on a nourishing diet, two grains of quinine were given three times a day, and a strict watch was kept to see that he took no laudanum. At the end of a fortnight he was in good health, his appetite was good, and, beyond his being unable to sleep for the first few nights, the discontinuance of the drug caused no ill effects whatever. This took place in January, 1875, and he has been frequently seen since. He has not touched laudanum since, and has had no recurrence of the epileptiform fits.

CASE 2.—S. J——, aged seventy-five, widow of a soldier, who was admitted in 1874 with a very extensive ulcer of the leg, contracted the habit of eating the extract of opium thirty years ago, when in India. In this case the use of the drug was discontinued suddenly, and no bad symptoms followed. The patient's ulcer healed up more rapidly than before.

CASE 3.—W. G——, aged forty, a musician, was under observation with very painful disease of the bladder and a stricture, for which he had been having for months three grains of morphia injected hypodermically every day. The stricture was treated by Holt's method, and the morphia was discontinued at once, the only evil result being a few sleepless nights.

CASE 4.—G. E——, aged twenty-five, had been in the habit of taking from half a teaspoonful to one teaspoonful of laudanum two or three times a day for the past four or five years, whenever he felt low-spirited or "out of sorts." He had taken that quantity regularly for the past six months. The use of the drug was discontinued at once. Some time after he declared the result to be increased weight and a general feeling of thorough sound health. In this case no quinine was given.

Patients who have been in the habit of taking opium in large doses for years are frequently seen at the Lambeth Infirmary, but Dr. Lloyd affirms that he has never seen any evil results follow the practice of discontinuing the drug suddenly. "I always," he says, "place them on a nourishing diet, without stimulants, and administer quinine in one or two grain doses.

COOMBE LYING-IN HOSPITAL, DUBLIN.—The annual meeting of this institution was held last week, and from the report it appears that in the lying-in department 550 patients were admitted, 94 were under treatment in the wards for various affections, and 1781 were attended to in their own homes. The expenditure has exceeded the income during the past two years by £769, and unless a considerable sum is forthcoming it may be necessary to curtail the benefits conferred by the charity.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Pathology of Lupus.—Operation for Relief of Patients suffering from long-standing Hypertrophy of Prostate or from Vesical Tumour.—Tumour of Bladder removed by Perineal Incision.

A MEETING of this Society was held on the 3rd inst., Mr. J. Birkett, Vice-president, in the chair. The meeting was an extra one, in order to admit of the reading of papers delayed by the recent debate. The main subject before the Society was that of suprapubic puncture as a measure of relief in cases of prostatic hypertrophy or vesical tumour, a paper by Sir H. Thompson being read in support of the procedure being adopted when catheterism becomes irksome and painful, and before actual retention demands such interference. As bearing on the same matter, a paper relating to the successful removal of a vesical tumour was contributed by Dr. Humphry. In the discussion that followed, Mr. K. Thornton, Dr. Keyes of New York, Messrs. Teevan, Howse, and T. Smith took part. The first part of the evening was occupied by a paper by Dr. Thin on the pathology of lupus, the chief point in which was the demonstration that the "giant cells" in this growth are produced by altered blood-vessels.

The following is an abstract of the paper on the Pathology of Lupus, with especial reference to the appearances described as "giant cells," by GEORGE THIN, M.D. The author prepared and examined portions of lupus tissue obtained from a case treated by excision by Mr. Morrant Baker, at St. Bartholomew's Hospital, with special reference to several points in the pathology of the disease to which attention has been lately directed. He finds in this case confirmation of the views of Friedländer and Thoma in regard to the mode in which the cell-infiltration and the destruction of tissue proceed. Groups of cells accumulate around certain bloodvessels as so many centres, each group constituting a nodule, the different nodules enlarging and finally coalescing. The disease extends by travelling along the bloodvessels, and the nodules form most conspicuously in the most vascular parts—namely, amongst the sebaceous glands, hair-follicles, sweat-glands, and in the papillary layer. The sweat-glands were carefully examined, with a view to determine whether evidence of epithelial growth (as has lately been described by Professor Lang, of Innsbruck) could be found, but with a negative result; all the changes observed consisting in different phases of progressive destruction of the gland cells as the lupus infiltration becomes denser. The condition of vitreous swelling and degeneration of the vascular coats, as described by Professor Lang, was observed, both in sections and in isolated vessels; but no evidence of growth of the capillary wall as a source of lupus infiltration was obtained. The first lupus cells are found immediately external to the bloodvessels, and, as regards size and appearance, have much similarity to colourless blood-cells. As the nodule forms these cells become larger, and undergo some chemical change, as the contents of the nodules stain differently from the cells in the earlier stages. The author thus agrees with Thoma in considering that exuded white corpuscles are the probable source of the cell-infiltration. The appearances described by Friedländer as "giant cells" are analysed in the paper. They were found in the nodules of the sizes and forms described by that observer, and are identified as being similar to the elements so described by Schüppel and other writers as characteristic of tubercle, but the author cannot find any evidence that they are elements of a new growth, or that they are developed from epithelioid cells. On the contrary, he has traced them backwards through connected stages to changes in the blood-vessels and their contents. The granular contents of the so-called cell are the products of disintegration of red blood-corpuscles, which first become welded into a homogeneous mass, this mass eventually becoming granular. Stages in which unaltered red corpuscles are still found in the mass, and in which the mass is only granular at some parts, can be found on the periphery of the diseased area; a characteristic eosin-staining persisting uniformly throughout these changes. The peripheral nuclei of the "giant cell" can be traced to the endothelium of the intima; and the nuclei, which are more rarely found in its centre, are identical with those of colourless blood-corpuscles. The processes of the "cell" are connective-tissue elements connected with the adventitia of the vessel. The coats of the vessel appear to have been distended at the affected part, the "cell" being sometimes traceable as continuous with a bloodvessel of much narrower calibre. Different cells are connected by strips of vascular wall. The author succeeded in isolating a cast of a portion of a vessel, which was composed of a granular substance containing a few white corpuscles, and which had the optical and staining qualities of the so-called protoplasm of the giant cell. It is pointed out that the giant cell of lupus and tubercle is not identical with the giant cell of sarcomata, granulation-tissue, &c., the latter element not being connected necessarily with a bloodvessel, and finding its type in the *myclopláque* of young bone. Although the giant cells of lupus and tubercle are identical objects, it does not therefore necessarily follow that the diseases are of a similar nature, as the primary cause of the affection of the walls of the vessel may not be the same in each instance. In regard to lupus, the evidence seems to point to the origin of the disease in the vessel itself, which is sufficient to account for the cell-infiltration, the molecular disintegration of the fibrillated connective tissue and glandular elements, and the mode by which the morbid process extends.—Mr. HOLMES thought that Dr. Thin's conclusions as to the vascular origin of the "giant cells" would harmonise with the assumption that it is through them that the disease was propagated to the neighbouring tissues; and this, again, would be in strict accordance with clinical experience of the great value of measures for the local extirpation of lupus, as opposed to constitutional treatment formerly in vogue.—Mr. GASKOIN asked whether the giant cells occurred in the lupus-tubercles, which were sometimes very superficial?—Dr. THIN, in reply, said that the pathological appearances in the bloodvessels would very well accord with Mr. Holmes's suggestion as to the spread of the disease. The changes were best seen in the skin beyond the limits of the disease as apparent to the naked eye, extending on all sides in the vessels of the papillary layer, and sometimes downwards in the vessels around the sweat-ducts and even into the fatty tissue, forming deep-seated nodules. The "giant cell" was an advanced stage of the change in the bloodvessels, and the point of practical importance was that the affected part should be freely and widely extirpated.

The following is an abstract of the paper "On an Operation for the relief of Patients who suffer severely from long-standing Hypertrophy of the Prostate or from Vesical Tumour, with retained Urine," by Sir HENRY THOMPSON. When the patient has long ceased to pass urine by his own efforts, and has to pass the catheter with great frequency, and often with pain and difficulty, may it not be desirable to place a tube *en permanence* in the bladder, making an opening above the pubes for the purpose? This may be done safely and simply, since there is a route into the bladder, by means of a staff, as in the "high operation" for stone. But, as in these cases the bladder is usually small and contracted, it is to be opened rather behind than above the symphysis pubis, so as to make certain of not injuring the peritoneum. This may be done without difficulty by following the instructions laid down. The author has applied the proceeding only in very extreme circumstances, with the view of rendering the short remains of a closing life tolerable, in three cases for hypertrophied prostate, in one for cancer, and in one for villous tumour. And he proposes the question, May it not be desirable to adopt such a procedure in some instances at a somewhat earlier period in the history of such cases?

A paper communicated by Professor HUMPHRY "On a Case of Tumour of Bladder removed by Perineal Incision," was then read. A man, aged twenty-one, in Addenbrooke's Hospital, in September, 1877, had frequent painful micturition, great straining, blood in urine, with pus and crystals of oxalate of lime. Sound gave only negative information. Symptoms of about two months' duration. A mass could be felt, apparently in the bladder. The suffering being extreme, Professor Humphry made an incision into the bladder as for the lateral operation for lithotomy, and found a firmish tumour with a ragged surface, attached by a pedicle to near the orifice

of the right ureter. Partly by the finger and partly by forceps the pedicle was torn through, and the tumour was extracted by lithotomy forceps. The root of the pedicle was scraped out with the finger-nail. After a day of comparative ease the pain returned with great severity, requiring the injection, subcutaneously, of morphia, which had to be increased to large doses and continued for more than two months. Then the pain diminished and gradually subsided; the wound healed and the patient completely recovered, and was quite well eighteen months after the operation.

Mr. KNOWSLEY THORNTON said that had the tumour in Professor Humphry's case proved too large to be removed through the perineal wound, there would not be much risk in removing it above the pubes, even by opening the peritoneum, provided the operation were done antiseptically. He knew of cases of ovariotomy in which the intestine had been torn and sewn up with fine suture, and another where a rent in the bladder had been similarly treated, with no ill result; and provided the urine could be rendered aseptic (and this might be done by the use of quinine solutions, as proposed by Mr. Nunn), a growth, although involving the walls of the viscus, might be removed through a clean-cut incision in the bladder with comparative safety. As such growths usually occurred near the orifices of the ureters, the cicatrisation of such an incision would be less likely to lead to occlusion of the ureter than the healing of a ragged wound.—Dr. KEYES (of New York) mentioned the case of a gentleman over sixty years of age, suffering from enlarged prostate, whose general health was infirm, and in whom, from inflammatory disturbance, catheterism became almost or absolutely impossible. A suprapubic puncture was made and a tube introduced, this tube being a double one, and constructed like a tracheotomy tube. It was about four inches long, so as to reach well down into the bladder, and the plate attached to it was constructed like that in a tracheotomy tube with a universal joint. It was worn for nine months, when the patient died from some intercurrent disorder. There was some suppuration in the prostate, which was also the seat of a new growth. But the procedure, which was just the same in principle as that described by Sir Henry Thompson, was attended with great relief, and he thought it was one which might with advantage be adopted in many cases.—Mr. TEEVAN thought the papers would direct the attention of surgeons to a somewhat untrodden path. His early impressions that prostatic trouble was only attended with the inconvenience of frequent catheterism had not been confirmed by his subsequent experience, which taught him that once catheterism was commenced the patient was condemned; that within ten years or so, from increasing infirmity and other reasons, a false passage was often made, cystitis followed, and a fatal termination occurred. So that he asked whether surgery ought not to try and do something more than simply afford the relief provided by catheterism; ought not the cause of the obstruction to be, if possible, removed? For the obstruction was purely mechanical; and prostatic growths causing it had been removed by Sir W. Fergusson and Mr. Bryant, whilst in Paris M. Mercier had for many years practised excision of the third lobe where there was increasing difficulty or frequency in the passage of catheters. Mr. Teevan thought that the readiest mode of removal would be by the rectal operation, for the relations of the growth could be well made out by exploration through the rectum, and by simple division of the septum between the gut and the membranous urethra the surgeon could at once come down on the prostate. The situation and extent of the growth could be readily made out and its removal effected, whilst bleeding could be easily controlled. He hoped that surgeons would direct attention to this matter, and that cases would be heard of in which the obstructing cause had been removed, and micturition again rendered possible.—Mr. HOWSE said that the Society must be grateful to Professor Humphry for the record of his case—one of a very difficult class to deal with. As to the advisability of opening the peritoneal cavity, he would yield to none in his willingness to open that cavity if necessary; but he must emphatically protest against its being done to reach growths of this kind. The risk of introducing septic fluid into the peritoneum from the bladder was too great. For he doubted the possibility of rendering the urine entirely antiseptic by the injection of fluids into the bladder. It would be impossible to so render it, when, as often happened in these cases, the ureters were dilated, for they would contain urine which the injection would not reach. Nor was it necessary to open the peritoneum. The bladder could almost always be so distended as to present above the pubes, and by a transverse incision above the pubes the viscus could be opened without any risk of wounding the peritoneum. He by no means depreciated the value of washing out the bladder with antiseptics. In a case read at the commencement of the session at the Clinical Society, where he had performed the suprapubic operation, he had himself washed the bladder out with thymol in order to render the urine aseptic. But the point was that, whereas a mere drop of septic fluid in the peritoneal cavity would lead to peritonitis (perhaps fatal), it was very different when this escaped into the cellular tissue. The bladder could be thoroughly explored by the suprapubic operation. He thought all must have met with cases of enlarged prostate showing the evils of prolonged catheterism. He asked wherein the novelty of Sir H. Thompson's paper lay. Suprapubic puncture had been often done for such cases. Perhaps the instrument employed was novel.—Mr. T. SMITH said that although the instrument might be new, it was a matter of question whether it were easier to introduce such an instrument than to distend the bladder with fluid and make a suprapubic puncture in the ordinary way. This was a favourite method with him in the treatment of cases of retention from enlarged prostate, and he bore testimony to the great relief experienced by the patient, who is able to urinate quite comfortably through his suprapubic aperture; and he quoted a case in point, where for many years no urine was passed per urethram, the patient being a solicitor in active practice, and able to attend to his duties. It was noteworthy that, although an elderly man, he was enabled to resume marital functions.—Sir HENRY THOMPSON, in reply, said that in considering operations for the removal of prostatic growths it must be remembered that it was very rare to find them pedunculated, and thereby fit for removal. As a rule the prostatic enlargement in elderly men sufficient to prevent micturition forms a large-lobed mass, which it would be impossible to remove. It was not in one in ten or one in twenty cases that a pedunculated "middle lobe" was met with. Nor was he aware of any single case in which a non-pedunculated growth has been removed; and in his own hands in only one case had any good resulted from removal of a tumour. He differed most emphatically from the view stated by Mr. Teevan, that cases of enlarged prostate requiring catheterism were as condemned to short lives as cancer. On the contrary, it did not shorten life to any extent; he could mention very many instances of this. There was one—a well-known member of the medical profession—who commenced catheterism at the age of sixty-five, and continued it daily till he was eighty-two, when he died, not from the prostatic affection, but from bronchitis. Another case was that of a gentleman who lived to the age of ninety, after having habitually passed a catheter from the age of sixty-eight; and he would add the instance of a well-known banker at Norwich, who died at the age of eighty-nine or ninety, and who, commencing catheterism at sixty, once told Sir Henry that he had passed the catheter on himself more often than any other surgeon had done in practice—viz., 35,000 times! Sir Henry then said that in a paper contributed to that Society some eighteen or twenty years ago, he had, with Dr. Messer, given statistics of Greenwich pensioners, and found that the mean age of the pensioners was seventy-three years; the mean age of those passing catheters habitually for enlarged prostate amounted to 72½ years. He added that on examination of a very large number of prostates after death during the inquiry showed him how very rare it was to meet with pedunculated growths. So he must strenuously protest against raising any kind of fear in the minds of those who suffer from enlarged prostate that their lives are in any way shortened thereby, or that they can, with any reason at all, be placed in the category of cancer patients. It had always been a matter of satisfaction to him to be enabled to assure such sufferers that the passage of the catheter was little more than a matter of toilet. Reverting to the question of removal by operation, he said that the injunction of Mrs. Glasse to "first catch your hare" should always be borne in mind before venturing on such hazardous cookery. In other words, the surgeon should be extremely careful as to the diagnosis of the form of tumour he proposed dealing with. The bladder could readily be entered by a suprapubic incision, and, as he had shown, without injection (for such bladders often resist forcible injection), and the extent and size of the tumour could be made out. The

only novelty in the operation he had brought forward was its performance in cases where retention is not present. Hitherto it had been limited to cases of retention. The instrument was similar to that used in the high operation for stone; in which advantage is taken of the hollow sound for guiding into the bladder the tube that is tied in through the aperture. It was no new operation; it had been practised by him ten years ago. He only thought it might, perhaps, be more frequently adopted with advantage. Speaking of the very interesting case related by Professor Humphry, he said that the reason why such measures had been spoken of as opening up an unexplored territory lay in the fact of the great rarity of vesical tumours which could be removed by operation. No one would dream of attempting the removal of encephaloid or scirrhous cancer of the bladder. Epitheliomata were flat and not pedunculated, and therefore could not possibly be so removed. Then villous growths, which might have been removed, were sometimes met with, but they were seldom solitary; very often they were multiple, and in a specimen he showed at the Pathological Society twenty years ago the mucous membrane was studded with villous processes. So that if a growth were removed with temporary benefit, the liability to recurrence of trouble was very great. Growths such as that described by Professor Humphry, pedunculated fibromata or sarcomata, were the rarest of all vesical tumours. He had only found two specimens of this variety in the London museums when he was inquiring into the subject some years ago. He therefore again urged extreme care in diagnosis before the dangerous operation of removal of an intra-vesical growth was entertained.

The Society then adjourned until the 10th inst.

CLINICAL SOCIETY OF LONDON.

Intussusception of Ileum into Cæcum associated with Polypoid Tumour.—Simulation of Ascites in Intestinal Obstruction.—Molluscum Contagiosum.—Paralysis of Serratus Magnus in Children.—Operation for Relief of Genu Valgum.—Gas in Peritoneal Cavity in Enteric Fever.—Amussat's Operation for Artificial Anus.

THE last ordinary meeting of this Society for the session was held on the 23rd ult., Mr. R. Barwell, Vice-President, in the chair. A large number of papers was read, and the meeting was prolonged beyond the usual time. The chief subjects discussed were molluscum contagiosum, arising out of a paper by Dr. S. Mackenzie, giving evidence in favour of the contagious character of the eruption; and the treatment of genu valgum, Mr. Brodhurst contending in favour of tenotomy and instrumental appliances as against Ogston's and allied operations.

Dr. COUPLAND read notes of a case, communicated by himself and Mr. Hulke, of Intussusception of the Ileum into the Cæcum through the Ileo-cæcal Valve, associated with a Polypoid Tumour; laparotomy on the fifth day; great immediate relief; death on the seventh day. The case was that of a spare, old-looking blonde, sixteen years of age, of highly hysterical temperament, who was admitted into the Middlesex Hospital on March 11th, 1879, having been seized the previous day with colicky pains and vomiting. She had just recovered from a similar attack, lasting a few days, and was said to have suffered in the same way some two years before. The bowels had been moved naturally that morning, but no blood had been passed. On admission the paroxysmal abdominal pain was the chief symptom, but there existed a prominent cylindrical swelling in the upper part of the right iliac region, and an area of dulness below this. There was no general abdominal distension, and no constitutional disturbance. The case being regarded as one of fæcal accumulation and typhlitis, sedatives were given and enemata administered—the latter without effect. The vomiting, however, continued, being provoked by anything she took. The pain, less severe on account of the opiates, still remained, and no change took place in the swelling or extent of dulness. On the 14th she was obviously weaker, the vomiting was "bilious" in character, the abdomen more tympanitic. A large soap-and-water injection to the amount of four pints was returned discoloured and with a peculiar penetrating odour. The question of intussusception (between which and the former diagnosis the case had always seemed to lie) was now seriously entertained, and Mr. Hulke was consulted. He found nothing on rectal and vaginal examination, and after a further consultation with Mr. Nunn and Dr. Cayley, it was decided (seeing the patient's critical state) that the abdomen should be explored. Laparotomy was accordingly performed, and Mr. Hulke detected an intussusception of the ileum through its lower end into the cæcum. Reduction being found impossible, the ileum immediately above was secured to the lower angle of the wound and opened. Great relief followed, the vomiting and pain entirely ceasing, and the pulse gaining in force; but thirty-six hours after the operation the patient sank from the peritonitis which was present at the time of operation. The post-mortem examination revealed an intussusception of fully three feet of ileum, through its lowermost six inches and through the valve, the invagination extending for a distance of twelve inches into the colon. The lips of the valve and the surface of the gut included between them were deeply ulcerated; much lymph occurred between the serous layers of the invagination, whilst the central tube was filled with blood-clot, except for its upper three inches, which was occupied by a firm fleshy cylindrical polypoid mass, about the size of the little finger. There was slight general recent peritonitis. The other organs were healthy. The obscurity in the diagnosis, the absence of melæna, the time that elapsed before the symptoms became severe enough to point to complete obstruction, and the fact that the vomiting never became stercoraceous, were dwelt on. It was pointed out that this variety of intussusception was of comparatively rare occurrence. The coexistence of a polypoid growth (it was lipomatous in character), and its situation at that part of the gut which was the last to become invaginated, were also points of interest; the presence of the tumour doubtless preventing reduction as well as hastening the ulcerative process.—Mr. MARSH asked whether there were any cases of fæcal obstruction on record producing such symptoms as this case presented? for it was plain that owing to the error in diagnosis much valuable time was lost, and when surgical aid was invoked the case had passed beyond the time when such interference would have succeeded in effecting a reduction of the intussusception. Mr. Hulke had done all that could be done; but it seemed as if physicians should seek for surer signs of diagnosis, so as to call in surgical aid early.—Mr. BRYANT said the case was of great interest, but he confessed on hearing it that he felt much as Mr. Marsh did as to the question of diagnosis. It did not appear to him that the symptoms were such as characterise fæcal obstruction. The patient was seized with an acute abdominal attack, which subsided and then recurred; and then unfortunately, when the diagnosis was made, Mr. Hulke had but little chance of doing good. The history of the case was peculiar. There was absence of tenesmus or discharge of blood-stained mucus, and possibly this might have led to the discarding the idea of intussusception. The presence of a polypus was very interesting; the invagination was clearly produced by an effort of nature to get rid of the growth. He referred to a preparation in St. George's Hospital museum, where a growth similarly caused intussusception. He had thought that ileal intussusception through the ileo-cæcal valve was one of the most usual forms; and he remarked that blood was found in abundance in the invaginated gut, and yet did not appear externally.—Mr. HULKE, in reply, said that hæmorrhage from the bowel when present was a valuable sign, but he had frequently found cases where there was no passage of blood. When, as in this case, the obstruction and strangulation of the gut are very acute, he should not expect that blood would have escaped. The wonderful rally the patient made after the operation from her deeply collapsed condition before operation was very interesting.—Dr. COUPLAND replied that the evidence in favour of intussusception when the patient was admitted was too slight to warrant his calling in the aid of the surgeon. The case lay between that and fæcal accumulation with typhlitis, and no one regretted more than he did that in taking the simpler ground he had diminished the chances of recovery from early surgical interference, to the importance of which he was fully alive. At the same time, looking to the extremely strangulated condition of the bowel, and the position of the growth, firmly fixed as it was between the lips of the valve, he doubted if

reduction could have been effected even if such interference had been made at the outset. Statistics showed that this form of intussusception was by far the rarest of all forms, the commonest being that where, commencing at the valve, the invaginating cæcum drags the ileum after it into the colon.

Dr. MARKHAM SKERRITT (of Clifton) related two cases to show that dulness in the dependent parts of the abdomen, changing its site with alterations in the position of the patient, which is commonly regarded as the most reliable sign of ascites, may exist when there is no fluid in the peritoneal cavity. The first case, fully reported to the Society on Feb. 14th, was that of a patient admitted into the Bristol General Hospital with intestinal obstruction from what proved to be a plug of fibrinous exudation. When the patient lay on his back there was dulness in both flanks as high as the anterior superior iliac spines; but when he turned on either side the uppermost flank became resonant. Post mortem, the small intestine was found to be greatly distended with liquid fæces and gas, and there was no fluid in the peritoneal cavity. The second case was that of a boy aged sixteen, admitted into the Bristol General Hospital five days after the onset of symptoms of intestinal obstruction. Here also there was dulness in both flanks when the patient lay on his back, and there was resonance in the uppermost flank when he lay on his side. At the post-mortem examination a coil of small intestine was found to be bound down by tough adhesions; the gut above was greatly distended with fluid fæces and gas, and there was no fluid in the peritoneal cavity. The following explanation was given of the simulation of the physical signs of ascites in these cases: The gas and the liquid fæces in each coil of intestine necessarily obeyed the same physical laws as did the gas-containing intestines and the free fluid in ascites; that is, in each coil of intestine the gas would rise to the top in whatever position the patient lay, and the fæces would sink to the bottom; and this was appreciable to percussion on account of the great distension of the individual coils, and also of the large proportion of fluid fæces contained in them. According to this theory, when the patient lay on his back the dulness in each flank was the sum of the dulnesses due to the liquid fæces in the individual coils, and when he lay on either side the resonance in the uppermost flank was the sum of the resonances produced by the gas in the same individual coils. The existence of this physical sign in the absence of ascites had apparently not been before described, and the fact was of some practical importance because this source of fallacy in the diagnosis of ascites would be met with in cases where the presence of peritoneal fluid would be of considerable diagnostic value: it would present itself only where there was arrest of passage of fæces. This stasis might be due either to a mechanical obstacle or to enteritis or peritonitis simply; and the apparent presence of a small quantity of peritoneal fluid would in such a case be strongly in favour of the existence of peritonitis, and therefore against the utility of surgical interference. It was therefore necessary to remember that in cases where there was great distension of the intestines with liquid fæces, the common physical sign of ascites might exist when there was no fluid in the peritoneal cavity.—Dr. COUPLAND mentioned a case of acute intestinal obstruction (from volvulus due to a Meckel's diverticulum) recently under Dr. Cayley's care in the Middlesex Hospital, where the greatly distended ileal coils were so full of flatus and fluid fæces that the signs of peritoneal effusion were present during life.—Dr. TAYLOR asked whether the sign of fluctuation-wave across the abdomen was yielded in these cases; still the shifting of dulness of the flanks from change in position was one of the surest signs of peritoneal effusion.—Dr. SKERRITT replied that no fluctuation-wave was obtained, but that sign was frequently absent in cases of ascites when there was yet sufficient fluid to yield dulness in the flanks.

Dr. STEPHEN MACKENZIE read notes of cases illustrating the Communicability of, and some other points connected with, Molluscum Contagiosum. These cases were brought forward, not on account of their rarity, but to illustrate the contagious character of the disease—a point on which English dermatologists were agreed, but which foreign dermatologists still appeared to doubt. In the first series a mother and four children were affected and two of the latter re-infected. A maternal aunt living exactly opposite also suffered from the same disease at the same time. The fourth child was first affected and communicated the disease to the baby. The latter was temporarily cured; but re-acquired the disease in his face and communicated it to its mother, whose breasts were covered with as many as from thirty to forty mollusca, as shown in a drawing. The sixth child was next affected, and the fourth, who first contracted the disease, was re-infected. The fifth child was affected at the same time as the preceding. The mother's sister, living exactly opposite, had two tubercles of molluscum contagiosum on her face at the same time. She frequently nursed the children. In the next series, an infant, eighteen months old, was brought with numerous molluscum tubercles on her face, and her mother had two mollusca on her breast, of which she appeared ignorant. These patients were exhibited. The next series were two little children, living next door, associating much together, both affected with the characteristic tubercles. These patients were also exhibited. Next were narrated the cases of two patients with molluscum contagiosum who were said to have come in contact with persons similarly affected. A case was also given in which a family predisposition seemed to exist, for four out of six children had been affected between the ages of two and three years, no two being simultaneously affected. The youngest had not reached the susceptible age. An account was then given of some unsuccessful attempts to inoculate the disease. The sebum and expressed gland-substance had been rubbed into parts, and the matter introduced by scarification, but in no instance was the disease propagated. To ascertain whether the want of success was due to non-susceptibility in the persons experimented upon, a series of inoculations was made in persons the subjects of the disease, the sebum from their own molluscum tumours being employed. No better success attended these experiments.—Mr. MORRANT BAKER said that so long as any doubts were held as to the contagiousness of the affection, it was well that such cases should be brought forward. He had recently seen a case where the thigh and labium were affected with the eruption, evidently by local contagion, and also an instance where a mother nursing her child had some of the spots on her skin while the child had some on the face.—Mr. MALCOLM MORRIS thought that Mr. Wilson was alone among English dermatologists in not accepting the contagiosity view. He saw a case at St. Mary's Hospital last year of a mother whose breast had become the seat of the eruption, her infant having the molluscum on its face.—Dr. SANGSTER has at present under care a girl with two patches of molluscum tumours on the opposing surfaces of the thighs, and also on the vulva. He had seen two members of a family with molluscum. He believed that long-continued friction aided in the local inoculation from one part to another, and was not surprised at the failure of experimental inoculation, seeing that such experiments must necessarily be rough as compared with nature's processes. Cases where the eruption occurs in various parts of the body had still to be explained.—Mr. BROWN, when at the North-Eastern Hospital for Children, had seen several cases in children, but had not once seen the mother's breast affected as well as the infant. Cases were very common in the eastern districts of London.—Mr. HULKE said that he had frequently seen evidences of its contagion. Children were brought to Moorfields Hospital with molluscum on the eyelids, and the mothers often had it at the same time. He had also seen cases of self-infection between the scrotum or labium and the thigh.—Mr. MARSH corroborated the previous speakers in favour of contagion from his experience at the Children's Hospital.—Dr. MACKENZIE, in reply, said that warmth and contact, aided, probably, as Dr. Sangster had said, by continued friction, seemed to be favouring conditions for the transmission of the molluscous growths.

Dr. LEES read notes of two cases of Paralysis of the Serratus Magnus as a part of Infantile Paralysis. The cases were shown at a meeting of the Society a few weeks ago. 1. Elizabeth M—— was seized with general paralysis at the age of nine months. When brought to the Hospital for Sick Children the muscles in worst condition were those of the left shoulder and right leg. In most of the muscles of these limbs faradaic response was absent, and in many of the muscles of the left leg and also in the right deltoid it was much impaired. After the child had been brought to the hospital for a few weeks it was noticed that there was marked falling in of the left side of the front of the chest during inspiration. The scapula was drawn up to a higher level than the right scapula, the upper angle was drawn nearer to the spinal column, and the lower angle had left the chest wall and projected backwards, in marked contrast to

the scapula on the other side. These symptoms seemed to justify a diagnosis of paralysis of the serratus. On applying the electrodes of a battery over this muscle a forward movement of the scapula at once responded to a current from seventeen Leclanché cells on the right side, but no movement could be obtained by the use of a much stronger current on the left. It was possible that in this case the intercostals were also paralysed, and certainly the rhomboidei had suffered, there being no muscular resistance when the scapula was pulled forwards. The child's general condition had since improved, but the position of the scapula and the electrical reactions were nearly unaltered. 2. Herbert P——, aged twelve months, was found completely paralysed one morning early in December, 1878. When brought to the Hospital for Sick Children on Dec. 20th, it was found that in him also the parts most deeply affected were the left shoulder and arm and the right leg. The right deltoid also was decidedly paralysed. It was observed that the angle of the left scapula projected from the chest-wall. On turning the child on his back the left scapula fell away from the ribs. It was doubtful whether a less degree of a similar condition was not present on the right side also. Respiration was entirely diaphragmatic. There was no unilateral depression of the thoracic wall during inspiration. No response to electricity could be obtained in either serratus. This child had considerably improved under treatment. The right scapula was now in normal position, and the left nearly so. Some response to faradaism had appeared in both serrati, and both deltoids had regained much power. He could now raise the hand above the level of the shoulder on the right side, but was still unable to do so on the left. In both these cases the serratus was only one of many muscles paralysed, but the signs of its affection were distinct. Paralysis of this muscle was a rare condition, and Dr. Lees was not aware that attention had been previously drawn to it as an occasional complication of infantile paralysis.

Mr. BRODHURST showed a patient who had been under his care for Genu Valgum. She was seventeen years of age, and before the operation the internal malleolus of the right leg was ten inches and a quarter from the median line. A cast showing her former condition was exhibited. In January last he divided the biceps tendon, external lateral ligament, and ilio-tibial band, and forcibly straightened the limb. He then applied the usual orthopædic apparatus, adjusted from time to time, and in seven weeks the limb was straight. Mr. Brodhurst said that he had brought the case forward because so much had lately been heard of the advantages of osteotomy for this disease. There was no proof that the internal condyle was enlarged in this condition, and he, therefore, saw no reason for removing it, especially in children; he doubted if it were ever necessary. He had heard of surgeons who had performed the operation sixty or eighty times, and many as often as twenty times. He had lately seen several cases which had been so treated, and had found in some effusion, in many suppuration, in some genu extrorsum, and in some anchylosis.—Mr. REEVES thought it was early days to speak of the case as successful. He stated that he was the first to perform the operation Mr. Brodhurst had described, but had now abandoned it in favour of osteotomy. Langenbeck had forty years ago abandoned division of the external lateral ligament because he found it necessary at the end of two or three years to wear a support to remedy the yielding of the divided ligament. No one proposes to remove the internal condyle, but only to move it. In none of his cases had he had permanent effusion, in only three did suppuration occur, and there were cases of osteotomy in the continuity of the bone. He thought different cases should be treated by different measures, but subcutaneous osteotomy was, he thought, no more dangerous than a cut finger.—Mr. GOULD went further than Mr. Reeves, and thought the case was not a perfect success now, for the limb could only just be brought into the straight line, and there was free lateral movement. The weakness was not due to a lax external ligament, but to the internal lateral ligament, which by the altered position of the bones was rendered loose and had not shortened up. The advantage of Ogston's operation was that the internal lateral ligament was not thus loosened, both ends of it being moved. — Mr. BARKER regretted that the cases of anchylosis following Ogston's operation had not been recorded. He had carefully read up the literature of the subject, both English and foreign, and had not met with any fatal result, except the one he had himself recently recorded. He had had one opportunity of making an actual measurement of the condyles, and had found a distinct lengthening of the internal one. In a late number of Langenbeck's *Archiv* the results of careful measurements of several cases are given, and confirm the generally received opinion that the condyle is lengthened. — Mr. HOWSE thought it a great pity that, if there had been cases of anchylosis or suppuration, they had not been brought before the Society. He had himself performed the operation eight or ten times, and had seen many cases under the care of his colleagues. In none was there any bad result, and the procedure had the great advantage of not requiring any orthopædic apparatus. Mr. Brodhurst's operation left the ligaments lax, which always gives a great sense of insecurity. In this case the result was imperfect and decidedly inferior to that of Ogston's operation. It would be interesting to see the case in three or four years' time.—Mr. BRODHURST had practised the operation for the past six years with most excellent results; nothing could be better, there being no return of distortion. He therefore thought it was unnecessary to see this case at the end of three years. The result at present was very good. There was fair mobility; the knee was straight and the limb useful, and he could not understand how it could be improved. Langenbeck discarded the operation, because he could not supplement it with useful apparatus. In reply to Mr. Barker he stated that Billroth says the internal condyle is not enlarged. The cases of ill-result from Ogston's operation had been met with in private practice, and it was not easy to bring them to the Society. [At Mr. Howse's suggestion the patient was here introduced. She walked slowly and with evident difficulty with the aid of two crutches. When the apparatus was removed it was found that the limb could not be bent beyond a right angle, and that, apparently owing to the weak internal lateral ligament, there was free lateral movement, and the patient could only stand when supported by both hands.]—Mr. MARSH hoped the patient would be exhibited next session.—Mr. BARWELL thought that the joint was still very loose, and that there was no prospect of being able to abandon the apparatus at present. He had himself performed osteotomy in several similar cases, and all at the end of seven weeks had been able to walk steadily. He thought it would be well if Mr. Brodhurst would exhibit this and cases similarly treated next session. — Mr. BRODHURST promised to bring the case forward next year.

Mr. G. BROWN read notes of a case of Gas in the Peritoneal Cavity in Typhoid Fever relieved by Puncture. The patient, a young man, aged twenty-one, came under Mr. Brown's care for typhoid fever in October last. The temperature was high throughout, ranging from 102° to 105·2° during the height of the fever. The case was complicated with double pneumonia. In the third week of the fever tympanites developed, at first localised to the intestines, but a few days later the physical signs indicated that gas had escaped from the intestine into the peritoneal cavity, or was being generated in the cavity itself. The distension of the abdominal wall gradually became more and more extreme, the tympanitic note entirely masking the hepatic and splenic dulness, and it could be elicited over the sternum as high as the articulations of the fourth costal cartilages. Through upward pressure on the diaphragm there was urgent dyspnœa, the inspirations reaching as high as fifty per minute, and the heart was displaced upwards and outwards, so that the apex beat was half an inch outside the nipple, and in a line with it. Mr. Brown pierced the abdominal wall with a small aspirator trocar an inch below the umbilicus, and on withdrawing the cannula a rush of gas took place, which continued for several seconds. The gas was odourless. The relief was immediate; the heart regained its normal situation, and in a few minutes the respirations fell from fifty to thirty-six per minute. No ill-effects followed the operation. The patient succumbed, however, from the lung complications thirty-six hours after. As to the source of the gas, Mr. Brown dismissed the idea of perforation of the intestine on the following grounds—viz., 1st, the gradual development of the gas in the peritoneal cavity; 2nd, absence of symptoms of collapse, which might have been expected had perforation taken place; 3rd, the fact that the tympanitic condition of the colon and small intestine was unrelieved by the operation (had perforation existed, gas would probably have continued to escape into the peritoneal cavity after the operation, but of this there was no evidence, although the patient lived thirty-six hours afterwards); 4th, the fact that the gas was odourless. Mr. Brown advanced two theories

as to probable sources of the gas—1st, the gas might have passed by diffusion through the intestinal wall; or 2nd, it might have been derived directly from the blood by exosmosis through the delicate walls of the peritoneal capillaries; and this was the more probable from the fact that for several days previous to the distension taking place the blood was highly charged with carbonic-acid gas, in consequence of imperfect aeration in the lungs. Mr. Brown said he was unable to decide this point, and preferred to merely record the case in the hope that other observers would be able to throw more light upon the subject, should similar cases occur in their practice.

Mr. MORRANT BAKER read notes of a case of Imperforate Rectum for which Amussat's operation was performed. The case related was that of a female infant, who, when nineteen days old, came under the care of Mr. Baker at St. Bartholomew's Hospital, on account of imperforate rectum. The abdomen was enormously distended. There was frequent vomiting and the child was much exhausted. Chloroform having been administered, an attempt was made to find the lower end of the bowel through the short cul de sac which represented the anus. The bowel, however, could not be found, notwithstanding very free incisions; and, in spite of the great distension of the abdomen, no bulging of the parts could be detected, even during the action of the abdominal muscles. It was decided, therefore, after a consultation, to desist from further operative procedures in the neighbourhood of the anus, and to perform colotomy by Amussat's operation in the left loin. This operation was accordingly performed. Meconium freely escaped, and within a few hours the infant was greatly relieved. An elastic tracheotomy tube was inserted into the bowel through the wound in the loin, and had been worn continuously ever since. In this way all troubles which might have arisen from contraction on the one hand or prolapse on the other were avoided. A year after the operation it was noted that the child was well and wore the elastic tube, fæces passing only once or twice in the week. The abdomen was, however, not distended. Two years after the operation the note was the same, and the child, now nearly three years old, was shown to the Society, perfectly well in health, and still wearing the elastic tube in the loin. Instances of recovery, it was remarked, after the performance of colotomy for the relief of imperforate rectum, were curiously rare, and, probably, the case shown to the Society was the only one now in this country. The question as to the best operation to be performed in cases of imperforate rectum, in which the bowel itself could not be found at the outlet of the pelvis, was discussed, and Mr. Baker thought that, on the whole, a preference should be given to Amussat's rather than to Littré's method of colotomy. In reply to Mr. Barwell, Mr. Baker said that he proposed, when the child was older, to explore the bowel below the artificial anus, and, if possible, to devise further measures. He would bring the results before the Society.—Mr. BROWN pointed out that the child was nineteen days old when the operation was performed, a fact of importance as showing how long a case might be allowed to go on, and the rectum thus enabled to become more fully distended.

The Society then adjourned till October.

Reviews and Notices of Books.

A Digest of the Principles and Practice of Medicine, with a short account of the History of Medicine and Tables of Indian Materia Medica. By RUSTOMJEE NASERWANJEE KHORY, M.D. Brux., M.R.C.P. Lond., &c. Large 8vo, pp. 1056. London: Smith, Elder, and Co.

THIS portly volume, which is dedicated to the President of the Royal College of Physicians and to Sir Joseph Fayrer, K.C.S.I., is offered to the medical practitioner and medical student in the hope that it may be of use to the one for ready reference and to the other as a convenient means for revising his studies. To this end the author has endeavoured, with great labour, to bring together in one view a complete account of the causes, symptoms, and treatment of diseases. Following the practice of the earlier rather than the later writers on the practice of medicine, he seeks to state the results of observation and experience rather than the methods by which the results have been arrived at. Indeed, he avoids the discussion of doubtful questions and the elaboration of details, with the result of leaving the impression on the mind that the work contains the accumulated notes of lengthened studies. The work reads like a note-book, and Dr. Khory describes it as "essentially an embodiment, in a convenient form, of the contents of standard medical writers, and of the hypotheses and facts which modern research has given to the world." The account of Indian bazaar drugs, and the examples of prescriptions of Indian drugs, contain much to interest the English reader.

The Journal of Anatomy and Physiology, Normal and Pathological. Conducted by Professors HUMPHRY, TURNER, MCKENDRICK, and CREIGHTON. Vol. XIII., Part 3. April, 1879. Macmillans.

THIS part opens with a communication from Professor W. Osler, of the McGill University, Montreal, on a case of Obliteration of the Inferior Vena Cava, with great stenosis of orifices of hepatic veins. The paper is accompanied by a plate. Mr. Alfred Young gives a description of the male generative organs of the Koala Phascolarctos cinereus, one of the marsupials, which throws interesting light on the homology of the sinus pocularis and other accessory parts of the higher mammals. D'Arcy Thompson describes the long bones of the left forelimb of a fossil seal found in brick clay at Dunbar. Mr. Aitken describes and illustrates a form of motion spectrum, in which radiating lines drawn on a revolving disc, and followed for some time, appear, if the disc be suddenly stopped, to be moving in the opposite direction. Similarly, if anyone who, walking by the side of a park paling, and looking for some time at the grass on the other side, suddenly directs the attention to the road in front of him, he will see a swiftly moving spectrum, the lines of which run in the opposite direction. Dr. John Service gives sphymographic tracings of the action of the active principle of jaborandi pilocarpin. It appears to be antagonistic in its action to atropin, and to act essentially as a vaso-motor paralyser. Dr. McIntosh shows that, in opposition to the views of Dr. Thomas Williams, Magelona, a species of annelid, has *corpusculated* blood. He also describes in detail its circulatory system. Basil Morison supplies statistics in regard to the arrangement of the azygos and superior intercostal veins in the thorax. Mr. Stirling, of Edinburgh, gives a note on a curious habit of the electric fish, Malapterurus, which, it appears, does not take the trouble to hunt down its own prey, but waits till this is done by some other fish. It then startles the latter by an electric shock, sufficiently severe to make it vomit, and at once consumes the ejected matters. Dr. Foulis continues his remarks on the development of the ova, and gives three plates. This is a valuable paper. Professor Turner mentions the anatomical peculiarities observed in the dissection of a negro. Messrs. Coats, Ramsay, and McKendrick give a provisional report on the effects of chloroform, ethidene, and ether on blood pressure. Then follow the usual reports and abstracts of papers.

A Dictionary of Chemistry and the allied branches of other Sciences. By HENRY WATTS, B.A., F.R.S., F.C.S., Editor of the "Journal of the Chemical Society"; assisted by eminent contributors. Third Supplement. Part I. London: Longmans and Co. 1879.

THE rapid progress which chemistry is making at home and abroad is strikingly shown by the bulk of the supplements by which from time to time Mr. Watts maintains the value of his deservedly celebrated dictionary. The present volume of over 800 pages carries to the letter F the record of chemical discoveries made during the last five years. It is compiled with the author's usual care and skill, and will, of course, be essential to all who are interested in theoretical or applied chemistry.

As usual, a large portion of the volume is occupied with

pure organic chemistry, the seemingly interminable benzene derivatives outweighing all others; but important articles on physiological, agricultural, and mineral chemistry are abundant. Thus the articles headed Bile, Blood, Ferments, and many others of similar character, will be studied with advantage by many of our readers.

Mr. Watts has done the great bulk of the work himself, but Professors Mills and Thorpe and Mr. Warrington have contributed several highly valuable monographs. We trust the rest of the supplement will appear before long.

OUR LIBRARY TABLE.

A Manual of Practical Chemistry: the Analysis of Foods and the Detection of Poisons. By ALEXANDER WYNTER BLYTH, M.R.C.S., F.C.S., &c., Analyst for the County of Devon, and Medical Officer of Health for the North Devon Combination of Sanitary Authorities. Charles Griffin and Co. 1879.—This book overlaps to some extent the large and useful "Dictionary of Hygiene and Public Health," published by the same author in 1876, and we think that in future editions of the latter work the analytical portions might with advantage be omitted. The present work is in most respects a satisfactory synopsis of the best modern methods for the analysis of food and poisons, and contains, besides, a great deal of useful information on the medical and legal bearings of the subject. The lists of authorities given under each heading are, moreover, full, and therefore valuable. The great defect is the scanty information in regard to microscopic methods, which in so many cases are the only ones applicable. In this respect, but in this respect only, the book falls far behind Dr. Hassall's well-known work. Both, however, will, no doubt, be used by every analyst.

Essays on the Treatment of Deformities of the Body. By F. R. FISHER, F.R.C.S., Surgeon to the National Orthopædic Hospital &c. London: J. & A. Churchill. No. I. The Treatment of Pott's Disease.—This is the first of four short essays, in which Mr. Fisher intends to review the modern methods of treatment of deformities. It is pleasantly written, but adds nothing to our present knowledge on the subject. The main question discussed is the value and mode of application of Sayre's "jackets." Mr. Fisher holds that in all cases where the disease is at all acute or progressive, treatment should be commenced by a period of perfect rest in the recumbent position, and that the "jacket" should not be applied until the acute symptoms have subsided; and he advocates the use of poroplastic felt in place of plaster-of-Paris. Nothing is said on the treatment of the most serious complications of the disease, and the essay deals with the subject in a scanty and incomplete manner.

Report of a Localised Outbreak of Typhoid Fever in Bristol, traced to the Use of Impure Milk. By DAVID DAVIES, M.R.C.S., Medical Officer of Health for Bristol, &c. pp. 20. Bristol. 1879.—In this pamphlet Dr. Davies gives an account of a localised outbreak of typhoid fever in Bristol, which occurred during the months of July and August, 1878, and which he traced to the use of milk from a particular dairy-farm. The pamphlet is illustrated with maps and a plan, but it is to be regretted that some of the more noteworthy parts of the account are given in the words of his reports made to the sanitary authority at the time. These reports necessarily embody many things that were of purely local and passing import, and while breaking that continuity of the story of the outbreak which is of interest to the profession generally, they needlessly hamper the reader.

Anatomie Iconographique Stratifiée Structure de la Humane. Par F. G. LERMERCIER, M.D., Officier de l'Académie, &c. — This is a representation of a human upper molar tooth, magnified to one foot in length, cut vertically, and divided into four movable layers, so as to bring into view successively its minute and marvellous anatomy as viewed through the microscope. To the late Mr. Tuson, we believe, is due the idea of exhibiting the anatomy of the human body by a series of movable layers, and although we do not remember his having thus illustrated the structure of a tooth, still it would in no way have lessened the credit due to M. Lermercier had he recorded this fact. We have, however, much pleasure in drawing attention to this work, which has been most carefully compiled, and with a due regard to accuracy in every detail, believing that it may serve to extend the knowledge regarding these important structures beyond the region of specialism.

La Lumière Electrique; Journal Universel d'Electricité.—We have received the first two numbers of this journal, whose appearance has followed close upon that of "The Electrician" in this country. Its avowed object is to popularise a knowledge of the science of electricity, and to give to workers in its practical branches a means of becoming informed of the almost daily advances which are being made in every part of the civilised world. We find in the second number a detailed account of the recent exhibition in the Albert Hall, besides many other papers of practical and scientific interest. The paper is well printed, and appears to be carefully edited.

The Fight with Infection: what to do when Scarlet Fever, Diphtheria, Typhoid, &c., enter our Homes. By WM. STEPHENSON, M.D., F.R.C.S.E., Regius Professor of Midwifery and the Diseases of Women and Children in the University of Aberdeen. 8vo, pp. 66. Aberdeen: D. Wylie and Son. 1879.—This work is devoted to a discussion and description of the *private* duties which devolve upon all in the presence of infection; in other words, the domestic management of infection, as contradistinguished from the *public* duties which devolve upon the community as a whole, and as defined by sanitary law. The book is of peculiar excellence, and medical men will find it most useful and helpful as a guide for their patients on the subject of which it treats.

Notes on the Diseases affecting European Residents in Japan, upon the basis of all available Statistics. By STUART ELDRIDGE, M.D., one of the Surgeons to the General Hospital, Yokohama, Secretary of the Board of Health, Yokohama. Printed for Private Circulation.—This is a reprint of a paper which appeared in the Medical Reports of the Imperial Customs of China. It is full of interest to the geographical pathologist.

The Nature and Treatment of Rabies or Hydrophobia. By THOMAS M. DOLAN, L.R.C.P.E. &c., Physician to the Halifax Fever Hospital. Second Edition. Baillière, Tindal, and Cox. 1879 — It is simply necessary to note the publication of a second edition of this work, and that for the first time the author's name is attached to it.

THE SPIRILLUM FEVER OF BOMBAY.

To the Editor of THE LANCET.

SIR,—I beg to repeat the announcement that the spirillum fever of Bombay (identical with famine or relapsing fever, or typhus recurrens) may be readily communicated to the *Macacus radiatus*, a common quadrumanous inhabitant of our forests here, by inoculation of the blood of a fever patient. I have now repeated this experiment, or the similar one of inoculation from one monkey to another, upwards of a dozen times, and have met with only one or at most two failures to reproduce the disease in question, which, for the most part, has been unequivocally manifested by both marked general symptoms and abundance of the attendant blood parasite. Post-mortem appearances, too, are equally concordant.

I am, Sir, your obedient servant,

Bombay, 11th May, 1879. H. V. CARTER.

THE LANCET.

LONDON: SATURDAY, JUNE 7, 1879.

IT is to be hoped that no delay will take place either in the appointment of the Select Committee or in the commencement of its work. It is to be apprehended that the different sides of the House have agreed as to the constitution of the Committee, and that no further obstruction will arise on this point. Theoretically, a more perfect group of names might have been selected, but our feeling is that the problems to be solved are so simple and so obvious that nothing more is needed than for them to be simply placed before any dozen or score of the members of the House of Commons to be understood. A Select Committee of the House, especially at present, may be trusted to give due consideration to corporations and interests and old ideas. There is little fear of anything too thorough coming out of the inquiry. At the same time it will be deeply disappointing if the inquiry, as far as it goes, is not searching. For ten years this question has worried the Government, the profession, and the medical bodies—universities and corporations alike. The medical bodies have probably been prevented from reforming themselves so completely as they would have done from the feeling that the days of their individual action were numbered, and that legislation must inevitably happen to affect their position. Everybody concerned looks to the Select Committee to put an end to the state of suspense, and to place the questions which come before it on a satisfactory and an intelligible basis for a generation or two to come. This is no mean object. The efficiency of the rank and file of the medical profession is of immense moment to the public. The upper ranks of society can scarcely go wrong. They have to choose from the *élite* of the profession, and the reputation of their consultees is a guide to them. They need no assistance from Parliament in selecting between one Court physician and another, or one hospital surgeon and another. But it is a great responsibility for the State to have to put its *imprimatur* on the general practitioners, on whose efficiency the issues of life and death depend in every hamlet and town of the empire. What are the questions which claim consideration at the hands of the Select Committee? The chief of them are, in the order of their importance—

1. The constitution of the General Medical Council.
2. The powers of the General Medical Council.
3. The kind of duties which the Council should accept and those it should reject.
4. The constitution and number of the examining boards for the future licensing of persons to practise all branches of medicine.
5. The abolition of the licensing virtue attaching at present to the qualifications given by the individual bodies in Schedule A of the Medical Act of 1858, even where those qualifications are only given on conditions of study and examination stricter than those attaching to the acquisition of the diplomas of the Examining Boards whose creation is contemplated in the various Bills.
6. The more accurate definition of offences against the medical profession and the Medical Acts by those who violate the principles of professional conduct or who defraud the public by false representations.

Some intelligent member of the Committee will perhaps begin by asking why there should be any inquiry at all, and how all these important questions come to be raised, as they distinctly are raised in the various Bills before the House. The answer is not far to seek. It will be found in the evidence of those who have watched the working of the Medical Council. Hitherto Governments have been in a delicate, if not in a false, position. The Act of 1858 created the General Medical Council, and made it representative—very capriciously and roughly, but still, after a fashion, representative—of the various examining and educating bodies of the country. This being so, successive Governments have acted as if nothing more were to be done in regard to educational medical matters than to consult the General Medical Council, or the President of that body, who, by the way, represents a university that has done disgracefully little for medical education. It is almost useless to interrogate a body that is under criticism. A body is not called on, any more than an individual, to criminate itself. It naturally takes an optimist view of all its work. Of all public bodies, the General Medical Council has shown the greatest self-complacency and the most singular disregard of outside opinion, though shared by almost the whole profession. The Select Committee will naturally seek evidence of the Council's work from those outside the Council, and will take such evidence into account in considering the questions which we have enumerated. Evidence can be had of the work done by the Council, of the work left undone by it, of the rate at which it does its work, and of the enormous time it wastes in not doing it; of the almost complete absorption of the Council's time in the last two years in discussing questions of impending legislation, or in administering the Dentists' Act of 1878. All the questions we have enumerated are important, but not equally so. By far the most important are those which refer to the constitution of the Council, to its powers, and the kind of duties which should devolve on it. If the Committee can suggest such a recasting of the constitution of the Council that it shall represent bodies which are doing earnest work in medical education and examination and the views of the bulk of the profession as well as of the Crown, and that it shall cease to represent bodies whose continued existence, as involving a heavy tax on medical students and the complication of the examining system, can no longer be justified, they will earn the gratitude of the profession and advance the efficiency and reputation of the medical art.

The constitution of the new Examining Boards is only less important than that of the Medical Council. They should be few; one would be better than three, but three are far better than nineteen. The fees should be equal in each division of the kingdom, and so should be the severity of the examinations. The days of half qualifications must be ended as far as the licence to practise is concerned. It must be a complete qualification. And when the State ceases to recognise, for its broad and national purposes, half qualifica-

tions, it should also cease to recognise those bodies which give them. The great object before the Committee under this head is to diminish the worry of multiplied examinations to the student, while increasing their fairness and their efficiency.

SOME years ago glycerine was proposed as a supplementary food, capable, it was even said, of taking the place of cod-liver oil in the nutrition of the invalid. The recommendation was made upon theoretical grounds, and received little confirmation from experience. Careful observations which were made, especially by the late Dr. COTTON, at the Hospital for Consumption, failed to show that it produces any effect on nutrition such as results from the administration of cod-liver oil. The opinion was thus formed that glycerine possesses little or no claim to be regarded as a food. The question has not, however, until now received much scientific investigation. To some researches by CATILLON and others we directed our readers' attention on a previous occasion.[1] The effect of glycerine on the interchange of material in the organism—i. e., its value as a food—has lately been further studied by Dr. IMMANUEL MUNK, in a series of experimental inquiries undertaken at Berlin, the results of which are published in the current number of VIRCHOW'S *Archiv*. The question is of interest not merely because glycerine has been proposed for the purpose above stated, and is occasionally administered as a vehicle for certain drugs, or to the diabetic as a substitute for sugar, but also because it is, in one sense, a constant article of diet. It is known that fat is decomposed in part in the alimentary canal, under the influence of the intestinal mucus, into its fatty acid and glycerine, and the amount of this decomposition is at present unknown. Again, all wines contain a certain quantity of glycerine, which is one of the products of the alcoholic fermentation of sugar. PASTEUR says that natural wines contain from six to eight grammes of glycerine per litre, while NEUBAUER puts the amount in the same volume at seven to eleven grammes. Moreover, it has been proposed to use glycerine as a preservative agent. MUNK has shown that the addition of two or three per cent. of glycerine to milk will postpone the lactic-acid fermentation for from eighteen to twenty-four hours. It is, therefore, important to know what influence is exerted by this substance on the vital processes. Of the toxic effect of large doses we possess information; the experiments of MUNK have reference to the effect of the digestion of small quantities. Whether any nutritive value can be ascribed to glycerine, and what quantity may be taken without interference with the processes of the body, are the points specially considered.

Any substance introduced into the economy may influence the decomposition of material in two ways—by increasing or diminishing, on the one hand, the destruction of the nitrogenous material, or the exchange of albumen, and on the other the excretion of carbonic acid and absorption of oxygen. The effect of glycerine on the latter has been already studied by SCHEREMETJEWSKI. But it is to the former point, the effect on the albuminates, that attention must especially be directed to determine the food-value of any substance. This is indicated by the effect on the excretion of nitrogen, and in the case of man and the carnivora the nitrogen passing away by the urine and fæces affords the necessary information. The value of the observations of CATILLON on this point is lessened by the fact that the diet of the animals experimented on was not strictly regulated.

It has been found that large quantities of glycerine produce hæmoglobinuria and also diarrhœa, both of which disturb the accuracy of observation. It was necessary therefore to give such doses of glycerine as should not produce these effects, and in the case of dogs not to exceed twenty-five to thirty grammes daily. These quantities were found by MUNK in no way to modify the excretion of nitrogen. Any influence of glycerine, at least in medicinal doses, on the exchange of albumen may thus be put aside. According to the ordinary definition of a food, glycerine does not possess any nutritive value. If, however, the urine only is examined, there is found a slight diminution in the amount of nitrogen, as observed by CATILLON. This is quite compensated for by the increased excretion by the bowel.

What is the fate of glycerine introduced into the economy? Is it decomposed or excreted?—and if the latter, in what form? When large doses are given so as to produce hæmoglobinuria, the urine contains a substance which readily reduces copper, but has been said, on the ground of its effects on polarised light, not to be sugar, but to be probably a decomposition- or transformation-product of glycerine. According to PLOSZ, moreover, it is not capable of fermentation. It is very difficult to say whether any unaltered glycerine passes away, since the detection of a small quantity in the urine is a matter of great difficulty. It seems certain, however, that the greater part, if not all, is decomposed in the organism, and that when moderate quantities only are given the decomposition is complete. It was observed by WEISS that the quantity of glycogen in the liver is increased by the administration of glycerine. From the analogy with other substances which have a similar effect, such as albumen, gums, &c., MUNK suggests that the glycerine absorbed from the intestine and carried by the portal vein to the liver is not itself transformed into glycogen, but rather, by its quick decomposition, limits the use of the liver glycogen, or furthers its formation from other materials. However this may be, the glycerine undergoes decomposition without its products having any influence on the changes in albumen, such as the carbo-hydrates exert. With reference to this, it may be remembered that glycerine has no chemical connexion with the carbo-hydrates, but is rather to be regarded as an alcohol—the tertiary alcohol of the propyl series.

The solubility of glycerine renders it highly probable that the greater part of that which is taken into the stomach passes rapidly into the blood. A small part may be unabsorbed, and in the lower part of the intestine may undergo fermentation and reduction, with the formation of butyric acid, carbonic acid, &c., although this decomposition can take place only in a neutral liquid—a condition not easy to obtain in the intestine. GORUP-BESANEZ has also shown that, in an alkaline solution, the action of oxygen in an active state breaks glycerine up into formic, propionic, and perhaps acrylic acids. There is some probability that, in the tissues, where similar conditions obtain, the same

[1] THE LANCET, vol. ii. 1877, p. 322.

decomposition may occur; and the intermediate products, propionic and formic acids, may be further oxidised to their ultimate products, carbonic acid and water. SCHEREMETJEWSKI showed that the ingestion of glycerine causes an increase in the excretion of carbonic acid, which CATILLON has affirmed may amount to 7 per cent. This increase in the production of carbonic acid must be accompanied by the liberation of its equivalent of heat, and so the generation of heat should be increased by the administration of glycerine. Hence there is the highest probability that glycerine may be of service in this respect, but that it is of no value as a tissue-food.

THE recent painful case, in which a member of the medical profession has been convicted of a grave offence against public morals and safety, might be passed over in silence, as something too humiliating to write or even think about, but for a remark of great sagacity made by the judge in pronouncing sentence on the prisoner. To this we would for a few moments ask attention. The observation that proof of wrong-doing lay in the fact that what was done was kept secret from other members of the medical profession, seems to us to embody in less than a dozen words the unwritten but supreme and all-comprehensive law of that profession. Everything that a member does should be done openly and, so to say, under the censorial eye of his brethren. When there is anything to conceal, or which cannot be submitted to scrutiny, the safe lines of practice or policy are certain to have been transgressed.

There is an old saying among divines, that a "case of conscience" is nearly always one in which the anxious inquirer desires to do something he *suspects* to be wrong. It is very much the same with cases of delicacy and questions of etiquette. Those who act honestly and openly on the dictates of honour are not, as a rule, troubled with misgivings, and seldom find themselves in positions from which escape seems difficult. They have nothing to disguise, they stand in no need of *finesse*, and although they may now and again appear a little headstrong, they may be trusted to act uprightly by the interests, and in time to win the confidence and respect, of their co-workers in the field of science. Those, on the other hand, who are perpetually harassed by doubts, and scarcely dare to stir for fear of tripping, are in continual peril of committing some blunder which will land them in the midst of countless embarrassments. No man who shapes his conduct with the ever-present consciousness that the full light of day falls on his every act is likely to go astray or give offence to those around him. The profession has declared expressly and strongly against all hole-and-corner proceedings and dark policies in the personal conduct and relations of its members, but if there had never been any formal embodiment of this principle in words, it would constitute the fundamental law of our autonomy. It is easy to see that this one precept of perfect candour covers every conceivable question. What a man is free to avow before his brethren he may do without scruple; what he needs for his own sake, for his good name, or for his supposed interests, to hide, must be unworthy, if not absolutely unlawful. A rigid and just application of this test will never fail to ensure a practitioner from the possibility of merited censure, and such openness as the policy indicated implies is certain in the long run to inspire trust and to command esteem. Underhanded and veiled proceedings, meanwhile, are, with scarcely a possible exception, of a nature to require the disguise thrown over them, and, therefore, essentially bad! This general description is true of the thousand-and-one difficulties and entanglements that occur between incautious members of the profession and the public and among themselves.

The Colleges have wisely formulated bye-laws against secret remedies and modes of treatment. Every violation of these regulations is not only a breach of rule, but an insult to the common interest and self-respect of the profession. The science of healing is as open as the science of nature, of which it forms a part. No proprietary right can exist in relation to any subject of knowledge. What one medical man has discovered is the common property of all, and no honourable labourer in the field of inquiry can deem it consistent with his duty to reserve information or trade on secrecy. In respect to remedies this is universally recognised by all respectable members of the profession; and in regard to special modes of practice the same is true. It does not, of course, follow that when a discovery is made public to the profession it must be immediately recognised as common property; but those who have achieved positions of trust and general respect have ever been instant in season and out of season in proclaiming the discoveries they have made, and in time the profession has come to recognise their value and reward the discoverers with their confidence. There is therefore neither reason nor excuse for the pretence we sometimes find urged, that the man who has delved for a secret treasure has a primary claim to recompense for his discovery. We hold it to be of the highest importance to the *morale* of the profession that its members should neither prescribe nor sanction the use of secret preparations; still less should they adopt private modes of treatment. Again: reserve in practice, beyond what may be necessary to the welfare of patients, is manifestly opposed to the highest purposes of the profession. It is not only due to the common interests of science, but to public safety, that such a community of knowledge and purpose should exist among practitioners as may conduce to the general advantage. It is not for mere personal advancement medical men become associated for scientific objects and intercourse, but with a view to the sharing of those grave responsibilities which arise out of the management of cases of disease. It is important that this should be understood, not only inside the pale of the profession, but beyond it. Men who are ostracised from the fellowship of their brethren in practice may be generally considered to stand outside the bounds of confidence.

No man ever yet made a permanent success in medicine who did not obtain the ratification of that success by the common voice of his profession. Brief popularity may, indeed, be secured by the appeal to public estimation, but it is by the members of his own profession a physician, surgeon, or general practitioner must be finally judged and his position determined. They alone are competent to appraise the real value of his work. It is necessary that this fact should be reasserted, as occasion arises, in the presence of public opinion; and we embrace the opportunity offered by a dis-

tressing and humiliating occurrence to warn those who presume to form their own estimate of practitioners without the means of performing that duty with safety, that the only test of fitness, and the only measure of genuine work, is that supplied by the position accorded to a medical man by his peers and fellow-workers. If this were more generally understood by the lay community, mistakes would be less frequent, and what every now and again happens—namely, the elevation of a poor or weak man to a false position by the lever of popularity cunningly applied to his own advantage by adroit methods of appealing to public favour—would be impossible. Medical men are, or ought to be, chiefly appreciated in their scientific character, and the estimate formed of their work can only be determined by the judgment of experts. A good scientific position is a guarantee for the responsible discharge of professional duties, not only in their technical, but in their moral and social aspects. In a word, the true scientist is a worthy citizen, because he obeys implicitly the unwritten law of the profession, and does nothing in the dark.

WE referred very briefly last week to a well-won victory gained at the annual meeting of the Royal Medical Benevolent College on the 29th ult., when the Governors by a very large majority carried a resolution requesting the Council to alter the bye-laws in such a manner as to secure the appointment of a Committee of Selection in or about April of each year. It is proposed that this Committee shall investigate the claims of all the candidates, and choose a list of applicants, whose needs they consider most urgent, equal in number to the advertised vacancies. The usual balloting papers will be made out as at present, and, in addition, a slip containing the names of those selected by the Committee will be forwarded to each and every governor. It will be seen that, though perfect liberty as to voting will exist as at present, the governors, one and all, will be furnished with what the majority believe must prove to be a useful and reliable guide. As such we are persuaded that it will be welcomed heartily by a vast number of subscribers. Several years ago a great step in the way of reform was made by abolishing the polling day, which ceremony was little else than an exhibition of almost shameless "cadging" for votes on the one side, painful and pitiful appeals on the other, and a sad sight of disappointed and despairing faces at the closing scene of a long, toilsome, and costly career of canvassing. It is hoped and believed that the reform achieved last week will do further good in way of saving expense as well as labour in the solicitation of votes. Most (at all events, a substantial majority) of the governors have been cognisant of the fact that as much money in some cases has been expended on canvassing, by friends and others, as would have kept the child for several years at an ordinarily good school, or bought an annuity for the pensioner in question. We insert elsewhere in these columns the letter of an old subscriber that interprets pretty well the feeling of the reforming party. We are particularly anxious on this, as on other occasions, when grave questions are discussed, to be perfectly fair and above-board, and to practise as well as preach the motto that heads the columns of our correspondence. Therefore we print also the letter of a subscriber who objects to the proposed change; but objects, as will be plainly seen, under a manifest misapprehension. We are glad to make this letter the occasion for reminding governors that the "slip" list to be sent with the balloting-paper is simply an expression of opinion on the part of a small body of subscribers, who have had before them the merits of, and all particulars connected with, each and every candidate, and who have been requested to indicate those who, in their minds, are the persons that most need the kind of help offered by the Medical Benevolent College. No sort of pressure, direct or indirect, will be put upon the governors; and those who desire to give their support to the most worthy, but cannot, from want of time or opportunity, sift deliberately the claims of all the candidates, will be grateful to the members of the Committee of Selection for thus guiding their votes into the true and proper path.

In congratulating the Reform Committee on the result of their three years' work, our remarks would lack courtesy if they did not include a tribute of gratitude and genuine compliment to the members of the Council for the very fair and polite way in which the discussion was conducted. We may remark here, parenthetically, that the College always claimed the support and sympathy of the late Mr. WAKLEY, who founded a scholarship in connexion therewith, and, had he lived, would no doubt have still further aided its special endowments. However great the differences may have been respecting the principles on which the elections should be conducted, Council and governors alike will heartily endorse the remarks of the chairman on the 29th ult., to the effect that the school, as to the quality of its teaching and as to its results, is second to none—collegiate, public, or private—in the United Kingdom.

Annotations.

"Ne quid nimis."

THE ILLNESS OF CARDINAL NEWMAN.

THE health of John Henry Newman is a subject of great interest to men of all creeds, and even to men of no creed. It would have been a dear price to pay for the tardy honour done to him at Rome had the journey and the excitement cost him his life. But it is very evident that this has been very near being the case. The admirable clinical account of his illness, conveyed in a telegram in *The Times* of Saturday last, shows this. It is so full of medical interest, heightened by its reference to one of the most remarkable men of the century, that we shall reproduce the points of it for our readers. It is not less interesting to us in that it shows that this great Father of the Church, venerable with the weight of seventy-eight years of life and strife of the best kind, is not free from that quality common in old men less saintly than he—a certain strength of self-will, not to say perversity. The first proof of this was in his determination to make the journey from Folkestone to Turin without stopping. Thereafter, we read significantly, "he was much fatigued, and, having caught a slight cold, was obliged to rest a few days at Pisa." He reached Rome on the 24th of April, and consulted Dr. Aitken. In two or three days there was so much bronchial irritation that Dr. Aitken advised a day or two's rest in the house—"advice which Dr. Newman unfortunately did not strictly follow." Strange that a mind so schooled to obey and submit should be so disobedient to medical authority. On the 2nd of May

slight bronchitis made confinement to the bedroom necessary. On the 11th he left the house; on the 12th delivered his famous discourse against modern Liberalism "without coughing," and began to look much better. After all this fatigue he visited his titular church, which is always cold and damp, and afterwards the still colder basilica of St. Agnes. The same evening, most naturally, he was attacked with a violent shivering fit, after which the temperature rose to 104·5°. The next morning all the physical signs of pneumonia of the left base, back and front, and of slight bronchitis over the back of both lungs, were developed. The fever subsided after the third day, and the weakness and irregularity of the heart, which at first were alarming, yielded to stimulants. On the 30th he was quite recovered. The relation of fatigue to these attacks of bronchitis and pneumonia respectively is very instructive. And though we have come to think more hopefully of late years of the prognosis of pneumonia, even of senile pneumonia, the recovery of the distinguished patient under such adverse circumstances does great credit to his physicians, Dr. Aitken and Dr. Erhardt.

CORONERS AND CAUSES OF DEATH.

IT will afford good ground for complaint if the proposed Coroners Bill be allowed to become law without more clearly defining the object of holding inquests, and the duties both of coroners and of juries with regard to carrying that object into effect. It is pretty generally presumed that one of the main causes for holding an inquest is to ascertain the cause of death, and Section 16 of the Births and Deaths Registration Act of 1874 especially provides that whenever an inquest is held on any dead body the coroner shall certify the finding of the jury with regard to the cause of death and other particulars required to be registered concerning the death. Notwithstanding this provision, verdicts of "Natural Causes" are continually being found by juries, certified by coroners, and entered in the death register, although these words convey but negative information as to the cause of death. At a recent inquest held in Carmarthen by the coroner for the borough on the sudden death of an old and respected tradesman of the town, no attempt was made to ascertain the cause of death. After the evidence of those who had last seen the deceased alive, and of those who first saw him after death, had been taken, the coroner remarked that other evidence could only be obtained by having a post-mortem examination, which, in this case, he did not think necessary, unless the jury wished it. The coroner, in the course of his remarks, is reported to have said: "It is not very important to the public to know whether a person died from disease of the heart, or from any other disease; the only question was whether he died fairly." We are fully aware that the coroner for the borough of Carmarthen does not stand alone in this interpretation of the duties of juries and coroners, with regard to the true object of holding inquests. We cannot, however, ourselves see how such an interpretation is to be reconciled with the provision of Section 16 of the Births and Deaths Registration Act quoted above. It is clear that there is considerable misconception on this point, which it is equally clear the proposed Coroners Bill should remove. It could scarcely be asserted that the words "Natural causes," or "Sudden death," convey such information of cause of death as appears to be contemplated by this clause of the Registration Act, and is required to be registered. It follows, therefore, that this clause should either be repealed, or that it should be rendered more generally operative by some provision in the new Bill. In the Bill brought in by the Home Secretary it is, indeed, proposed to repeal the clause in the Registration Act above referred to, but the substance of the clause is re-enacted in Section 6 of the proposed Bill in these words: "They (the jury) shall also inquire of and find the particulars for the time being required by the Acts relating to the registration of deaths to be registered concerning the death." It is important to ascertain whether this clause is intended effectually to prevent the return of such a meaningless verdict as "Natural causes."

MEDICAL MEN AND THE CLERGY.

THE clergy of all denominations have no reason to be dissatisfied with the correspondence we have lately published as to the propriety of medical men attending them and their families gratuitously. The correspondence began with a short pithy letter from a medical practitioner who had lately started practice in a watering-place. Having attended one of the clergy, and sent in an account, he got a reply to the effect that the patient had never in an experience of forty years paid a doctor's bill! "M. B.," writing two or three weeks later, having had extensive practice both in England and Scotland, said he had never known a medical man of any standing send in a bill to, or accept a fee from, a clergyman! Such statements are enough to show that there is a notion abroad that clergymen (we use the word in its broadest sense) have a sort of divine right to employ a medical labourer without paying him his hire. We can only regard such a notion as a relic of a time when the position of the clergy was one of discreditable poverty and dependence. It is due to them to say that the majority of our correspondents have abundantly shown that, as a class, the clergy are no parties to the notion, but pay their medical attendant with a befitting sense of their own independence and of his hardly-earned claims. We exclude altogether, and with the utmost sympathy, cases of straitened and inadequate means, which still exist, but which, to the credit of the churches, are much less frequent than they used to be. Many of the large denominations have arrangements for greatly mitigating the care of their clergy by provisions for life-insurance and for medical attendance on honourable and independent terms. It ought to be so in all cases. There are many reasons why the clergy should, as we believe the most of them do, pay their medical men like other people. First, because it is a good example which some of their flocks need to have set them. Secondly, and even more powerfully, because the gratuitous arrangement is apt to be a demoralising one on both sides, sapping independence, begetting little feelings of patronage on the one side, and expectations of touting on the other, which cannot be too severely denounced. The provident arrangement, as suggested by a correspondent, is eminently one that may be used here, by which clergymen, not being "honourables, or squires, or keeping their carriages or their hunters," may, for a sum within their means, secure the services, on dignified terms, of any member of the profession.

THE PRESENT COLD SPRING.

SO cold an April and a May as we have experienced in 1879 is probably almost unprecedented. Since 1850 there has been but one instance of a colder April (in 1860), whereas the May just ended was colder than any corresponding month in the past twenty-eight years. Taking the mean temperature of the two months, there is no approach in this period to the coldness of the past April and May. The mean temperature of April last at the Royal Observatory, Greenwich, was 43·2°, and 2·2° below the average April temperature in 100 years. On only five days throughout the month did the daily temperature somewhat exceed the average, while a large deficiency prevailed on most of the other days. In May the mean temperature was 48·4°, and 4·2° below the average mean in 100 years; only on four days during the month did the daily

mean temperature equal or slightly exceed the average, while the mean was below the average during the rest of the month. The average May temperature in 100 years was 52·6°, and only five times since 1850 has the mean temperature of May fallen below 50°; of these five instances of recent cold Mays, three occurred in 1876, 1877, and 1879, when the mean temperature at Greenwich was but 49·4°, 48·9°, and 48·4° respectively. The rainfall during the past two months was considerably above the average, 6·0 inches of rain having been measured on 31 of the 61 days in April and May at the Greenwich Observatory; the average rainfall of these two months is but 3·8 inches. The cold, rainy, and unusually sunless weather of April and May has undoubtedly affected the public health unfavourably, although it is difficult to estimate its full effect. The Registrar-General tells us, however, that in London alone, during the nine weeks ending last Saturday, 3985 deaths resulted from diseases of the respiratory organs, which exceeded the corrected average number from these diseases in the corresponding period of the previous ten years by 1224, or no less than 44 per cent.

PORT SANITARY ADMINISTRATION.

PORT sanitary administration has recently been placed in so strange a predicament by the extraordinary action of the Privy Council during the late plague-scare, that we turned with no little interest to the half-yearly report of the medical officer of health for the Port of London (Mr. Harry Leach), which has just been published, to learn with what sentiment that action had been regarded by the port sanitary authority. The report, however, relates to the half-year ending with Christmas, 1878, and so is concerned with a period immediately preceding the predicament to which we have referred, and touches upon the latter only incidentally. Nevertheless, it gives information which enables us to judge more accurately of the sort of mischief to this administration, and to the operation of the sanitary law of the kingdom as it affects ports, with which the Privy Council has threatened us. It has been suggested that when the Lord President of the Council stated, amidst the cheers of the House of Lords, that he was determined to rehabilitate the old Quarantine Act at any cost, he was merely talking to the quarantining powers of the Continent, with a view of staving off impediments to our maritime commerce which might else befall. Subsequent events, however, in respect to the so-called disinfection of certain cargoes of rags brought from Russia into English ports, proved that the Lord President had by no means, as was, indeed, to have been expected, condescended to throw dust into the eyes of foreign nations, but that, as representing the Privy Council, he was prepared to go any length in the re-establishment of quarantine as concerns plague, without regard to the existing sanitary administration of our ports or to the futility of quarantine as a real measure of protection against plague.

From Mr. Leach's report we learn in what the sanitary administration of the port of London consists—how it touches in detail all that concerns the sanitary condition of ships, docks, anchorages, and the health of crews. We learn also how very considerably the sanitary condition of the shipping visiting the Thames has been changed for the better since the port of London sanitary authority came into existence and began its operations, and how steadily this process of sanitary transformation of vessels is going on. We learn, further, how efficiently the work of dealing with the various infectious diseases brought by ships into the port is carried out, the patients suffering from them removed to hospital, and the general population saved from the mischief which would else have arisen to them from these importations. What is said here of the sanitary administration of the port of London may be said likewise more or less of all the ports in the kingdom where the authorities are doing their duty. It is difficult to conceive of the Quarantine Act being put in force without the operation of the sanitary law as it affects shipping being at once seriously disturbed—disturbed, moreover, at a time when, in the interests of the public health of the kingdom, it is necessary that the administration of the sanitary laws should be most jealously guarded and sedulously strengthened. The administrators of the Quarantine Act (the Customs) could not fail to be brought into awkward collision with the administrators of the Public-health Acts (the sanitary authorities). At many essential points the Quarantine Act would override the Sanitary Acts both in our waters and on land, and we should see the preposterous spectacle of a mere fiscal authority again set to do work which can only properly be done by a sanitary authority.

The promoters of the sanitary laws obviously never dreamed of the long-continued policy of the Privy Council as to quarantine being changed as has now been threatened. Quarantine had been dealt with for so many years as a political question, having no medical or sanitary signification, that the revivification of quarantine in its medico-sanitary aspects in this country might well be regarded as too improbable for consideration. We now know that the Privy Council seriously design such a revivification in the case of plague threatening the country. If the Government do not take measures by which, in respect to that disease, quarantine may be so used that its political, or, so to speak, politico-commercial requirements may be retained without endangering by its administration the sanitary work of the kingdom, we may have that work, particularly as it concerns vessels in our ports, seriously hampered in several important respects, if not altogether made impracticable at a critical moment. In other words, we may have work such as that which is being done by the Port of London sanitary authority rendered nugatory when its effective doing is most essential.

A notable part of Mr. Leach's present report concerns the sewage outfalls in the River Thames below Teddington. This part appeared in a separate form as a special report, and has already been dealt with in our columns.

BARE FEET.

A QUESTION has been raised in connexion with one of the large provincial schools, whether the children might not, with advantage, be allowed to adopt the practice prevalent in Scotland, Ireland, and many large districts on the continent and in the colonies, of going bare-footed. As against the custom of wearing bad shoes that will let in the water and are soaked in wet weather, and stockings which are rarely changed, there can, we think, be no ground to doubt the expediency of abandoning foot-coverings altogether. Nature will be her own shoemaker in the matter of protection, the cuticle being hardened just where a pad is needed and no where else, and she will amply provide for the due defence of the extremity against cold by establishing a more abundant supply of blood to the extremities. As a matter of fact, the heat of the body depends on the vital processes carried on within it, and these are amply sufficient to meet every want. Then, again, it is true, as the medical officer has, in the case to which we allude, reported, that if the foot is not encased in a hard frame or box which impedes the action of the muscles and joints, that organ will be capable of better work in walking and jumping, and it will be more fully nourished, in obedience to the law that makes the nutrition of every part and member of the body dependent on exercise for efficiency. To these considerations must be added, that when the extremities are habitually exposed there is less danger of cold-catching than

when they are "protected." On hygienic grounds, bare feet are certainly admissible, and the fact that foot-coverings are not employed by the inhabitants of regions with climates colder and more variable than our own is evidence that they are not indispensable, or, as we believe, conducive to health in England. Habit and fashion alone enjoin the wearing of shoes, and to those who in early life are accustomed to go without these articles of dress there is not only no hardship, but an immunity from many troubles—chilblains, corns, cramped toes, and tender feet prominently among the number.

IRISH MEDICAL ASSOCIATION.

THE annual meeting of this Association was held on the 2nd inst., at the Royal College of Surgeons in Ireland, Mr. Robert McDonnell, President, in the chair. The Council, in their annual report, referred to the passing of the Public Health (Ireland) Bill, 1878, as a subject of congratulation. The Vaccination Bill, introduced by the Irish Government, at present before the House of Commons, contained many clauses drawn up by the Association, but several important clauses had not been inserted in the Bill. Among other objectionable features of the measure, the fees allowed for successful vaccination and for medical evidence at vaccination prosecutions were less than those paid in England. Resolutions were adopted to the effect that medical officers of the Poor-law Service who had become unfit to discharge their public duties, or had served twenty years, or reached the age of sixty, should, as a matter of right, receive a superannuation allowance of not less than two-thirds of their official emoluments; that the issue of medical relief tickets needs amendment; that the Vaccination (Ireland) Amendment Bill requires assimilation to that of England; and that the Council be requested to persist in their efforts to have "The Registration of Births and Deaths (Ireland) Act, 1863," amended in accordance with the principles of the Bill drawn up by the Association, which was presented to the House of Lords in 1876.

NITRITE OF AMYL IN SEA-SICKNESS.

MR. CROCHLEY CLAPHAM, to whom is distinctly due the credit of introducing this remedy to the notice of the profession, again writes reminding us of the fact, and remarking that "with due attention to details he looks upon the drug as curative in at least 90 per cent. of all cases treated." By a reference to his first article on the subject, published in THE LANCET of Aug. 21st, 1875, it appears that during several trips across the Pacific, Mr. Clapham treated altogether 124 cases. In 121 of these, he tells us, success was evident and complete. The drug was administered by inhalation, three drops of the nitrite being poured on a handkerchief held close to the nose of the patient, the inhalation being conducted rapidly. A caution is added, to the effect that not more than three drops should be used in the absence of medical advice. In July, 1878, we published an article on the same subject by Dr. J. Rudd Leeson, who was successful in about three-fourths of the cases treated, the remaining fourth complaining of a feeling of sickness, but without vomiting. One or two cases did not improve in any way. Dr. Leeson thinks that three drops for women and five for men is the minimum dose, but that caution is required. Mr. Clapham says it is not a dangerous drug, except of course in cases where the arterial system is more or less rigid from osseous deposits. In August last Mr. Clapham and Dr. R. Leeson each contributed a letter to our columns, in which the former quotes some favourable experiences of Dr. Crichton Browne in crossing to Sweden, and Dr. Leeson gives a very emphatic proof of the comparative harmlessness of that drug, for the particulars of which we must refer our readers to THE LANCET of August 10th, 1878. On the 3rd inst. Mr. Dingle, surgeon to the Peninsular and Oriental Company's ship *Mirzapore*, gives a favourable account of the remedy, saying that in one day he administered it in at least a dozen cases, and that in all the effect was markedly successful, though in some instances it was necessary to repeat the dose, which he limited to three drops. But one of Dr. Dingle's patients has written to us, and says that, according to his observation on the occasion referred to, the drug ought to be administered with very great caution, *and always under medical supervision*. Later, as our readers will have observed, one or more favourable reports have appeared in these columns. Under such circumstances, and with such an accumulation of evidence, we consider it right, as Mr. Clapham suggests, to draw the attention of those who often "go down to the sea in ships" to the remedy. And we should recommend ship surgeons to take Mr. Clapham's standard—as a rule, to limit the dose to three drops, and not to take it except under medical advice. He also recommends that the patient, when under treatment, should be in bed, because a good sleep is generally the first result, from which the person awakes wanting to eat. It is usually better to allow one fit of vomiting to occur before the treatment is commenced, "to ensure the *bonâ fide* character of the seizure." Some, however, do not vomit at all, but are very ill, and with these he considers the nitrite to be equally successful.

CERTIFICATES OF THE CAUSE OF DEATH.

THE insurance offices are complaining, and not without reason, of the inadequate registration in many cases of the "cause of death." Such returns as "general decay of nature," "senile exhaustion," are vague, not to say unintelligible, and afford no information as to the actual causes, or even the modes of decease. We are not disposed to attach any great weight to the sorrows of commercial establishments, or even Government departments, which cannot obtain particular returns without paying for them; nor can we blame practitioners for refusing to supply gratuitously information which is worth having, and must be worth paying for; but it will be apparent to everyone that phrases such as those we have cited, and many like them—for example, in the case of children, "atrophy," and "congenital debility"—do not fulfil the requirements of the official form which practitioners are required to fill up. The interests of public safety require more precise information than that very generally supplied. In so far as the needs of commercial enterprise, or even a public health department, may press for returns more explicit than the simplest and readiest, we are not disposed to endorse the claim; but what is written should at least be precise, and it is indispensable that it should convey such evidence as to the actual *cause* of death as the interests of safety demand.

FROZEN LIVE-STOCK.

IT is strange that the proposal to import live cattle and sheep from distant grazing lands in a state of "congelation," as it is called, should have been seriously discussed. Whatever may be done with cold-blooded animals, it would manifestly be a barbarous practice to freeze warm-blooded creatures, even if life could be preserved during transit by this artifice. It may occasionally happen that an animal will retain a spark, as it were, of vitality during a long period of suspended animation induced by cold; but, as a general rule, the cattle and sheep so treated must be simply frozen to death. If it be found impracticable to preserve the carcases of beasts which have been frozen immediately after being slaughtered, it will manifestly be impossible to import them alive in a state of congelation. The process, if carried out, would simply amount to the horribly cruel pro-

cedure of reducing the vitality of an animal to its lowest ebb, and thereby prolonging the condition of dying until the body was so far on its way across the seas as to leave no time for decomposition before landing. It is a device to retard death in the dying by extending the process by which life is destroyed. Common-sense and humanity revolt against the proposal, and we can only hope an experiment surpassing the worst horrors of vivisection will be interdicted. The use of an anæsthetic cannot possibly prevent torture. The effect of the means employed to deaden or destroy pain during the act of freezing must pass away after a few hours, and in so far as the body retains vitality it will be likely to regain sensation. Nothing more needs to be urged against the proposal.

MENTHOL: A NEW ANTISEPTIC.

MENTHOL, or peppermint camphor, is a crystallisable body deposited from Chinese oil of peppermint on exposure to cold. It is met with in the form of small colourless fragrant prismatic crystals, not unlike sulphate of magnesia. In fact, when first imported from Japan, some twenty years ago, it was for a time suspected to be nothing but Epsom salts flavoured with peppermint. It is now known to have a definite chemical composition, and to be the camphor, or stearoptene of peppermint oil. It is but slightly soluble in water, although it imparts to it its characteristic smell and taste. It dissolves readily in alcohol and ether, and in oils, both fixed and volatile. It melts at about the temperature of the body, and when further heated volatilises without decomposition. From a series of experiments recently undertaken by Mr. Archibald Duncan, a student of the University of Edinburgh, it would appear that it is possessed of antiseptic properties similar to those of its homologue, thymol. At present it can hardly be regarded as a commercial article; but it could be readily imported from Japan, and there is no reason to suppose that its price would be prohibitive. An impure sample sent over from Canton, in 1872, was valued at 30*s.* a pound. We are not aware that it has been used in therapeutics; but strong oil of peppermint painted over the part has long been a favourite mode of treatment in China for gout and neuralgia, and it might prove useful in these complaints. The Japanese "Po-ho-yo," or neuralgia remedy, probably contains menthol.

NAVAL SURGEONS.

WE mentioned some days ago that due attention was not paid to the comforts of naval medical officers either afloat or ashore, in the matter of quarters. Thereupon, a surgeon in the Royal Mail Steamboat service writes to us, detailing at some length the discomforts to which he and his compeers are subjected in the ships of that company. In this case, the medical officer's cabin is described as situated between the seamen's closet and the scullery, and immediately opposite the engine-room and galley. *Apropos* of comforts, it is declared that in the earlier days of Greenwich Hospital, which was classed as a haven of rest for all varieties of naval officers; some of the bedrooms were so peculiarly constructed that it was necessary to stand on your head to shave. But we must not compare the comforts and discomforts of the eighteenth with those of the present century; and certainly, with the thermometer above 80°, and marine engines in your neighbourhood working up to 60° more, a cabin such as that above described cannot, under any circumstances, be a superlatively pleasant or healthy lodging. Hence, as we have indicated many times, shipowners and masters cannot and will not secure, except by what may be called good luck, really able medical men. Under any circumstances, the life on board for medical officers is not attractive, except quite as a novelty, and so the rule in this sort of work almost invariably holds, that by the time, if not before the time, that a doctor becomes really valuable as a marine medical officer, he leaves the sea, more often on account of preventable discomforts than of considerations connected with filthy lucre. Good nautical doctors must be gleaned from our ranks not on account of financial advantages, but because they like the sea and the life that it brings. There is a sufficient (if not an abundant) supply of men of our cloth with these requirements, if only their little creature comforts are fairly considered.

THE BISHOP OF ELY AS A SANITARY ADMONITOR.

THE appearance of bishops in the field of sanitary work is so rare that a recent excursion of the Bishop of Ely in the sanitary concerns of his episcopal city deserves a passing note. This learned dignitary has held himself called upon to address an appeal to the Local Board of Ely on the impurity of the water-supply of that city, and to express a hope that the Board would see fit of its own motion to take steps to rectify the evil, and in so doing give effect to the real wish of the inhabitants of the city, without rendering it necessary to ask for the intervention of the Government in the matter. The Local Board, in reply to his lordship, shows that it has not been by any means unmindful of its duties as to the water-supply, but that the question is really one of pounds, shillings, and pence, and the ratepayers have not yet given any indications of eagerness to incur the necessary cost.

THE FULHAM SMALL-POX HOSPITAL.

THE meeting recently held at Fulham to protest against the establishment by the Metropolitan Asylums Board of a small-pox hospital there, is another illustration of the difficulty which is experienced in making even educated persons understand the rudimentary facts involved in the mode of dissemination of contagious diseases. Sir William Palliser, C.B., presided, and Sir Charles W. Dilke, Bart., M.P., took part in the proceedings. The arguments used against the hospital were of the usual imaginative sort. If the cases brought together in the hospital had been scattered in private houses throughout Fulham, or elsewhere in that part of the metropolis, each case an uncontrolled and uncontrollable centre of direct and indirect, but, so far as the "public" is concerned, invisible and unknown mischief, it was obvious that the meeting would not have had a word to say, and its promoters would have been contented. But the moment these cases are segregated in a hospital, and are placed under circumstances calculated to do the least possible danger to the public, alarm is taken at the mere fact of their being brought to light, and the imagination is allowed to run riot in conjuring up fictitious dangers.

TESTIMONIAL TO DR. CARPENTER, C.B., F.R.S.

AT a meeting of the Carpenter Testimonial Committee, held at the University of London on May 10th, Earl Granville in the chair, it was resolved, on the motion of the Earl of Derby, seconded by Dr. Wm. Smith, that "subscriptions be invited towards a fund, to be called the 'Carpenter Testimonial Fund,' for the purpose of procuring a portrait of Dr. Carpenter, to be presented to the University as a permanent memorial of his long and assiduous labours on behalf of that institution." At the same time, Mr. Fitch, M.A., and Mr. Knight Watson, M.A., were requested to act as honorary secretaries, and Sir John Lubbock, Bart., M.P., and Dr. William Smith as honorary treasurers. The committee is a very influential one, and there is no doubt that the fund will speedily be completed. It may be added that intending subscribers should forward their donations to either of the hon. treasurers above named or to one

of the hon. secretaries, Mr. J. G. Fitch, of 5, Lancaster-terrace, Regent's-park, or Mr. C. Knight Watson, of the London Antiquarian Society, Burlington House.

PIPECLAY AT GIBRALTAR.

THE *Army and Navy Gazette* informs us that "this summer, in consequence of a reference to England by General Anderson, officers are, contrary to long-established custom, obliged to wear, not the serge coat, but the tunic on all occasions when the latter garment would be worn in the United Kingdom. This is rather hot on the subalterns, who have plenty of guards, especially on the officers of the three Highland Regiments, in whom the action of the skin is further stimulated by the cross-belt, a thicker sash than is worn by ordinary regiments, and a warm woollen kilt plaid." Can this possibly be true? or has our contemporary been made the victim of a *canard* from the Rock? If true, we congratulate the 42nd Regiment on the escape it has made from such an infliction. We presume that this argillaceous old General has taken advantage of Lord Napier's absence to bring forward his crotchet, for we cannot suppose the latter would have entertained the question for one moment. It would be interesting to know the grounds on which this retrogade pipeclay order was recommended, and still more curious to learn those on which the Horse Guards authorised a proceeding so subversive of the comfort of the officers, and so likely to prove injurious to their health. We understand that the last two summers were marked by an unusual prevalence of fever among the officers at Gibraltar. If this order be not rescinded the present may be expected to prove still more sickly to them. We trust that some member who has a friend serving there will take an early opportunity of asking Colonel Stanley for an explanation of this very curious proceeding. Failing any such friendly interference, we would recommend the case to the favourable consideration of the Royal Society for the Prevention of Cruelty to Animals.

THE BRICK-BURNING NUISANCE.

THOSE who have suffered the woful ill-effects of inhaling fumes from a brick-kiln will be surprised to find that in certain quarters a doubt is supposed to exist as to its being a "nuisance." Apart from the indirect mischief the odour of burning clay does, by compelling the occupiers of houses into which it may be wafted to close their windows, and the fits of coughing it entails on persons with delicate lungs, there are the nausea and sick headache which generally afflict individuals with what are called "weak stomachs." The suffering endured by no inconsiderable number of persons who are compelled to live near brick-fields is of a nature to render any measure which can be devised to mitigate the "nuisance" to which we allude a great boon. It is not only a *nuisance*, but one so intolerable that to many delicate organisms it constitutes a source of frequent discomfort, and may even lay the foundations of disease.

QUARANTINE.

ONE of Her Majesty's troop-ships, the *Tamar*, with details of invalids aboard from the Cape, arrived at St. Vincent last week, when the captain reported the existence of two cases of chicken-pox. The Portuguese authorities, therefore, ordered the *Tamar* into quarantine for twenty-eight days, although, according to the report of one of our contemporaries, Captain Liddell, the commanding officer of the *Tamar*, "protested that chicken-pox is not an infectious disease according to the usage of maritime nations." We cannot go quite so far as the gallant captain, and declare that chicken-pox is not infectious, but he might fairly have said that it is not the usage of civilised maritime nations to insist upon a quarantine of twenty-eight days for any disease whatever. Be this as it may, Captain Liddell very naturally telegraphed home for instructions, the practical result of which was the release of the ship, after a delay of some twenty hours, and her immediate departure for Portsmouth. It is strange that, in these days of rapid progress and sanitary advancement, Spain, Portugal, Turkey, and even France, should still hold to these antiquated, crude, and irrational systems, that cripple commerce, and in no sort of way prevent the spread or lessen the severity of epidemic diseases.

CHOLERA IN INDIA.

ACCOUNTS from India by the last mail describe cholera as very prevalent in the Bengal Presidency; from Benares to Rawul Pindee hardly a station but has had some cases; hitherto they have not been very numerous. At Meerut the 15th Hussars have had twelve cases, most of them fatal; the regiment had just returned from Kandahar, and lost several men in the railway journey from "Sher Shah" to Meerut. As bodies of pilgrims returning from the Hurdwar fair had travelled along this route, and used the very carriages which conveyed the 15th Hussars immediately afterwards, it is considered that the disease was *possibly* contracted by this means. Railway carriages are by regulation disinfected and fumigated after any suspicious case before being used again.

HOSPITAL SUNDAY IN LIVERPOOL.

WE understand that the Hospital Sunday Committee have been able to divide £8600 among the sixteen selected charities in the following proportions:—Royal Infirmary, £2580; Royal Southern Hospital, £1376; Northern Hospital, £1204; Dispensaries, £860; District Nursing Society, £559; Ladies' Charity and Lying-in Hospital, £516; Infirmary for Children, £430; Eye and Ear Infirmary, £430; Homœopathic Dispensaries, £172; Stanley Hospital, £172; Hospital for Infectious Diseases, £86; Consumption Hospital, £86; Cancer Hospital, £43; St. Paul's Eye and Ear Hospital, £43; Dental Hospital, £21 10*s.*; St. George's Hospital for Skin Diseases, £21 10*s.*

OUR SOLDIERS.

A "HOSPITAL PHYSICIAN" calls attention, in the *Pall Mall Gazette*, to the number of "broken-down lads from eighteen to twenty years of age who have been nearly made into soldiers, but are so deficient in stamina that they could not even complete their term of short service," who are applicants for medical advice at the London hospitals. He implies, rather than directly states, that the Army medical officers are to blame for passing these youths into the service. Now the military surgeons are quite as well aware as the "Hospital Physician" that it would be very desirable to take no men under twenty-one years of age into the army. But what are they to do? The regulations authorise the enlistment of lads of eighteen if of a given height and fair muscular development. The medical officer has no means of obtaining evidence of the lad's age beyond the statement made on oath in the attestation, and if the recruit comes up to the regulation height and chest-measurement, and has a fair muscular development, he would not be justified in rejecting him because he would prefer a man who had completed his growth. If voluntary enlistment is to be the rule of the service, it must be taken with all its drawbacks, and this one of taking immature lads, who may, and often do, break down in the training, is by no means the least. But how is it to be avoided? We do not believe the country would stand the adoption of compulsory military service, and under no other system could we obtain an adequate supply of men of full age for the

army. The responsibility for the enlistment of these lads rests, not with the examining military surgeon, who, as a rule, does his duty very carefully, but with the military authorities, who make the regulations, and, still more, with the country at large, which will not adopt a system of compulsory service. So long as we adhere to voluntary enlistment so long must we be prepared to hear of these unfortunate cases.

THE BIRMINGHAM MEDICAL BENEVOLENT SOCIETY.

THE annual meeting of this Society was held on the 30th ult., under the presidency of Mr. T. Watkin Williams. The report recites that the funds of the Society amounted to £9070; and grants to the amount of £460 had been made to fifteen recipients. Of £145 obtained by donations, £107 had been obtained by the President. Mr. W. H. Sproston was appointed president-elect, and the resignation of the treasurer, Mr. Berry, was received with much regret. Dr. Johnston and Dr. Harrison Clifton were elected vice-presidents, and the honorary secretary was re-elected.

REINFORCEMENTS FOR THE CAPE.

A LARGE number of army medical officers have been placed under orders for Natal, and will embark in the course of the next few days. Surgeon-Major R. W. Jackson, C.B., proceeded in medical charge of the troops on board H.M. troop-ship *Jumna* on the 4th inst., and on arrival at Durban will join the staff of General Sir Garnet Wolseley.

THE CANAL BOATS ACT.

PROSECUTIONS of a mild character continue to be undertaken under the provisions of the Canal Boats Act. The proprietors of three boats at Liverpool were summoned for not having registered, and a nominal penalty was inflicted. There seems, however, to be a general idea that the Act is merely a sort of sop to philanthropy, and may possibly serve as such, but is not likely to accomplish any practical sanitary good among the community the members of which it is intended to benefit.

THE EPIDEMIOLOGICAL SOCIETY.

AT the annual meeting of the Epidemiological Society, on Wednesday, the 4th inst., Sir Joseph Fayrer, K.C.S.I., M.D., F.R.S., was elected President, in the place of Surgeon-General John Murray, M.D., who retires from the chair, after having occupied it for two years.

A DINNER of the medical officers connected with the Volunteer forces will be held at the Holborn Restaurant, on Friday, June 13th; Surgeon-General Munro, C.B., President of the Volunteer Ambulance Department, in the chair. It is proposed that the anniversary dinner shall be perpetuated and made an occasion for the discussion of regimental affairs. Gentlemen who purpose attending on this occasion are requested to send their names to Lieutenant Maclure, Hon. Sec. of the Volunteer Ambulance Department, 6, Whitehall-yard, before the 11th inst.

THE Ruthin Guardians, acting as the rural sanitary authority, have taken a retrograde step in sanitary administration in the appointment of medical officer of health. Up to this year this sanitary district of 12,500 population, and 89,400 acres, was worked by Mr. W. D. Jones for a salary of £70 a year. Now it has been decided to divide the district into three, each division to be commensurate with the Poor-law districts. The district medical officers are to be the medical officers of health, each for his own district, and are to divide the modest sum of £45 between them as remuneration for their services in this capacity. As no motive beyond the apparent one of economy is assigned for this change, we shall watch with some curiosity for the sanction of the Local Government Board; the more so as one of the proposed districts was specially reported upon in 1877-78, by one of their medical inspectors, in consequence of the prevalence of diphtheria in it.

WE regret to hear of the death from cholera at Nynee Tal, Himalayas, of Surgeon-Major Alexander R. Kilroy, Army Medical Department. Mr. Kilroy obtained his first commission as assistant-surgeon in April, 1855, was promoted surgeon on the 11th April, 1868, and surgeon-major in 1875. He served for many years in the Royal Artillery in the Straits and in India.

ON Monday last a meeting of graduates of the Queen's University in Ireland was held at Belfast, when resolutions were passed condemning the O'Connor Don's University Bill, and affirming that the time had arrived when the claims of the Queen's University to representation in Parliament should be recognised.

THE Homerton and Stockwell Small-pox Hospitals were recently reopened, both having been for some time closed for repairs and cleansing. It is also announced that the Hampstead Hospital is closed against the admission of new cases.

THE SEAMEN'S HOSPITAL SOCIETY.

THE annual report of this useful institution has recently been published, by which it appears that a total of 1744 patients have been treated during the past year, 472 of whom were discharged cured, 493 as convalescent, 429 as relieved, and 53 as incurable. It appears that 20 absconded, 118 died, and 159 remained on the books on the first day of the current year. Mr. Johnson Smith, the resident surgeon, who is responsible for the professional report, recites that 156 represented the average daily number of in-patients, 9·02 representing the number of patients to each bed.

The most noteworthy feature in the annals of this hospital for the year 1878 is the decided and progressive decrease in the number of cases of pyæmia. Mr. Smith says: In 1875 the number of deaths from this cause had fallen from 10 to 7; in 1876 there were 6 deaths, in 1877 4 deaths, and in the past year 2 deaths only. Since 1875 there has been but one death from erysipelas. Whilst from 1871 to 1874 inclusive there were 43 fatal cases of pyæmia and erysipelas, and the proportion of these to the total number of deaths from all causes was about 10·5 per cent., from 1875 to 1878 the deaths from the above causes were 20 in number, and the proportion to all the deaths during this period not higher than 4·5 per cent. He attributes this very good result to the antiseptic treatment (Lister's) adopted since 1874, and instances some cases that occurred under the hands of his colleague, Mr. Davies Colley, who has treated venous varicosity in the lower limbs by excising portions of the dilated veins, as well as one interesting operation performed by Mr. Amphlett (as acting surgeon) for the reunion of widely separated portions of fractured patella. We take it that in the later days of the old *Dreadnought* such operations in the surgical and lowest deck of that ship would most assuredly have, so to speak, "gone wrong" in a pyæmic, gangrenous, or some other mal-hygienic sense. It is proper, however, to record that the sanitary condition of the wards has been, or should be, very much enhanced by sundry improvements in the drainage arrangements that have been made in this Admiralty property by the committee of a charitable institution, at a total cost of nearly £300, £120 having, according to the report of Mr. Burdett, been spent last year, and some £150 in 1875. It occurs to us that, though the managing committee of the Seamen's, or, indeed, of any other Hospital are bound to do all they can to benefit the patients committed to their charge, it seems an unjust thing that guinea subscriptions, collected with difficulty and with great industry and energy, should be spent on buildings not the

property of the Society, and belonging indeed to by far the richest imperial establishment in the United Kingdom. Not a farthing of this money will ever be reimbursed to the Seamen's Hospital Society by the Admiralty, although it is spent for the direct benefit of those to whom "my Lords" must inevitably look mainly in times of war to man the fleets and protect the shores of Great Britain.

HEALTH OF LARGE ENGLISH TOWNS
IN THE TWENTY-SECOND WEEK OF 1879.

DURING last week 4891 births and 2903 deaths were registered in twenty of the largest English towns. The births were 291, and the deaths as many as 467, below the average weekly numbers during 1878. The deaths showed a further decrease of 126 from the declining numbers in recent weeks. The annual rate per 1000, which in the twelve preceding weeks had declined from 29·1 to 21·4, further fell last week to 20·5, a lower rate than in any week since the middle of October last. The lowest rates in these towns last week were 14·8 in Brighton, 15·4 in Plymouth, 15·8 in Leicester, and 16·2 in Portsmouth. The rates in the other towns ranged upwards to 24·2 in Hull, 24·4 in Manchester, 24·9 in Oldham, and 27·7 in Newcastle-upon-Tyne. The high rate in Newcastle-upon-Tyne was in great measure due to the excessive fatality of zymotic diseases. Judging by the metropolitan returns, which are published by the Registrar-General in greater detail than those for the provincial towns, the death-rate from diseases of the respiratory organs continues to exceed the average, owing probably to the unseasonably low temperatures that have recently prevailed. The deaths referred last week to the seven principal zymotic diseases in the twenty towns were 368, and three more than those returned in the previous week; they included 106 from measles, 91 from whooping-cough, 89 from scarlet fever, and only 23 from fever, chiefly enteric. So few deaths from fever have not been recorded in these towns in any week on record. The annual death-rate from these diseases averaged 2·6 per 1000 in these towns last week; it was 0·8 and 1·0 in Portsmouth and Brighton, whereas it ranged upwards to 3·2 and 4·3 in Sunderland and Newcastle-upon-Tyne. Scarlet fever showed the greatest proportional fatality in Sunderland and Leeds; measles in Newcastle-upon-Tyne and Bradford, and whooping-cough in Sheffield. Three deaths were referred to diphtheria in Bradford and two in Brighton. Of the 23 deaths from fever returned in the nineteen large provincial towns, two occurred in Portsmouth and two in Newcastle-upon-Tyne. Small-pox caused 8 more deaths in London, but not one in any of the nineteen large provincial towns. The number of small-pox patients in the Metropolitan Asylum Hospitals, which was 353 towards the end of February last, has since declined with but slight fluctuations, and was 199 on Saturday last; 44 new cases of small-pox were, however, admitted to these hospitals during last week, against 48 and 49 in the two preceding weeks.

Correspondence.

"Audi alteram partem."

TREATMENT OF GENU VALGUM.

To the Editor of THE LANCET.

SIR,—It is not, I think, without reason that I express myself as somewhat dissatisfied with your editorial remarks on the 31st of May on my communication to the Clinical Society at the last meeting. In consequence of the late hour, and because other papers were to follow mine, I did not read my paper *in extenso*, but only mentioned some points of chief interest. Notwithstanding, however, that I made my communication as short as possible, the time of the meeting had expired when the discussion was brought to a close, and a special vote was taken to prolong the meeting for half an hour, so that the business of the evening might be completed. You have thus expressed an opinion on a paper which has not been read.

I exhibited a cast of perhaps the worst case of genu valgum with which I have ever met; and I produced the patient to show her with a straight leg, and with power of flexion and extension at the knee. This result was gained, not by osteotomy, but by division of the biceps tendon, the external lateral ligament, and the ilio-tibial band. The case shows an excellent result so far as it goes at present.

You are mistaken in supposing that crutches were used, and that the patient was unable to walk except with crutches and an apparatus. If crutches have ever been used it was only when she first began to walk. Soon afterwards she discarded them, and has not, I believe, since used them. She did not bring them to the Society's rooms with her. And not only have I seen her walk without crutches, but without any artificial support whatever. It was, in fact, after the apparatus had been removed that she walked in the room.

These osteotomies are becoming so frequent—I may, perhaps, say so recklessly frequent—that I was anxious to bring this case under the notice of the profession, and was unwilling to postpone it until another session.

It must not be supposed that I have not other data from which to draw conclusions. I have practised this operation for six years, and have thus had time to acquire evidence in support of my opinions. At this time I will only relate one other case. A boy, eight years of age, was brought to me with genu valgum and partial anchylosis. He was brought direct from another consultation, where osteotomy was recommended. To show, however, the opinion which was entertained in this case, at least of the proposed operation, the parents were asked to consent to amputation, should it be found to be subsequently necessary. The biceps tendon and the external lateral ligament were divided, and the adhesions were broken down; and the child has now a perfectly straight limb, with useful motion at the knee, and is able to take any amount of exercise without wearing apparatus or support of any kind.

I can have no doubt from what I have seen and heard that this new hobby—osteotomy—is being ridden to death.

I am, Sir, your obedient servant,

Grosvenor-street, W., June 2nd, 1879. B. E. BRODHURST.

MEDICAL TITLES.

To the Editor of THE LANCET.

SIR,—I read with much pleasure your leader upon "consultees" in THE LANCET of May 24th, and it has tempted me to fetch out of my desk a letter upon the same subject which I had written some time ago with a view of sending it to you for publication, but refrained from doing so on account of the Government Medical Bill just then occupying the attention of the House of Lords for the first time. However, I do so now; and if you will kindly read the following, I think you will find that your ideas of medical reform and mine run somewhat in the same groove.

Like the majority of my medical brethren, I believe all should enter the profession through one portal, the examination being alike in England, Scotland, and Ireland; and the holder of such Government diploma should be entitled to practise medicine, surgery, midwifery, and pharmacy in any part of Her Majesty's dominions, and should be designated "State Doctor," thus giving every practitioner of the healing art the title of Doctor from the beginning of his career. Medical men should be classed into four grades, their rank being estimated according to their style, or rather kind of practice: first grade, Queen's Physician, Queen's Surgeon; second grade, Consulting Physician, Consulting Surgeon; third grade, Consulting State Doctor; fourth grade, State Doctor. The State doctor to practise all branches of the profession, including pharmacy. The consulting State doctor to practise as above, but not to supply medicines. The consulting physician and surgeon to confine themselves more or less to the practice of pure medicine and surgery, and to be allowed to see patients without an introduction from other medical men, providing such patients are not at the same time under the care of other doctors. The Queen's physicians and the Queen's surgeons must, on no account, see patients unless in the presence of and in

consultation with a representative of either of the three preceding grades, the fees of such consultees to be paid before consultation through the medium of the ordinary medical attendant, the lowest fee to be received by a Queen's physician or surgeon for home consultation to be fixed at five guineas; for visit and consultation (within three miles) ten guineas. Such fees as these would give men like Jenner and Paget and others of their professional status only what is their due, if we rank them with their equals in the legal profession.

Before a State doctor could become a consulting State doctor, he must take the L.R.C.P. and L.R.C.S.; then as consulting physician or surgeon the M.R.C.P. or M.R.C.S.; also they must be Bachelors of Medicine. The Queen's physicians and surgeons must be Doctors of Medicine and Fellows of their respective colleges. The Queen's physicians and Queen's surgeons may or may not have a post at court: the title does not indicate royal appointments, but shows the possessor's rank in the profession.

If your wish, Sir, is Utopian, my ideas, as stated above, may be said to be extremely visionary; however, there must be a beginning to everything, and if from perusing this letter medical reformers and politicians can obtain a wrinkle, I shall be more than satisfied.

I am, Sir, your obedient servant,

Fulham-road, S.W. HENRY W. WILLIAMS, M.D.

COMPULSORY REGISTRATION OF INFECTIOUS DISEASE.

(LEICESTER IMPROVEMENT BILL.)

To the Editor of THE LANCET.

SIR,—It is of the utmost importance that the medical profession throughout the kingdom should know that powers, at once extraordinary and compulsory, are being given by Parliament to municipal authorities in various parts of the country.

The Leicester Corporation has now in Parliament an Improvement Bill, containing a clause to the following effect:—That every medical man, under a £10 penalty, must inform the corporation of every case of certain infectious diseases, such as cholera, typhus, typhoid, erysipelas, small-pox, diphtheria, puerperal and scarlet fevers, that may occur in his practice, public or private.

The medical men of Leicester as a body strenuously protest against such obligation being imposed upon them. They are allowed no discretion, and are liable to be placed in the position of criminals for a simple act of omission. The main objections are as follow:—(1) The penal clause; (2) the complications which would, owing to breach of confidence, of necessity occur between patient and medical man; (3) the clause not affecting irregular practitioners, such as unqualified assistants, chemists, and herbalists; (4) that many patients for fear of being reported would not seek medical advice, and thus become unchecked sources of infection; and (5) that any such legislation should be *imperial*, not local.

We, the medical men of Leicester, have opposed, at considerable expense, this Bill in the House of Commons, and so far unsuccessfully. Our profession has ever been in the van of sanitary reform, progress, and action. In Leicester we have given the corporation much help. We have advised the corporation as to the infantile diarrhœa—the scourge of the town; we have, unsolicited, given them information of the last three outbreaks of small-pox, and now we are insulted by being placed under penalties.

We learn that certain corporations have applied to the Local Government Board to bring in a general Bill for this compulsory registration. The president told them that the profession was very "touchy" on this subject, and that he should not bring in a Bill without consulting the heads of the profession. The officials of the Local Government Board advise these corporations to smuggle in a clause to obtain this power in their various "improvement Bills" where it would not be noticed, and so escape opposition. It was then suggested that after some twelve or fifteen towns had obtained this power, and had it in working order, the Local Government Board would be able to bring in and pass a general Bill affecting the whole of the country!

This Machiavellian advice has so far succeeded only too well, and unless the whole profession now comes forward to help Leicester in opposing this Bill in the House of Lords next July, a fatal precedent may occur. Future opposition from medical men in other towns will be futile, and so the way to a general Bill will be paved. We wish to state clearly to the medical men of the country that unless they wish to have penal clauses of a similar nature imposed upon them (by a general Bill) they must materially support us in our present opposition. We have opposed as far as our means permit, and for future opposition we appeal with confidence to the profession throughout the United Kingdom. On behalf of the profession in Leicester,

I am, yours most faithfully,

C. R. CROSSLEY,
President of the Sub-Committee of the Leicester Medical Society.

P.S.—Subscriptions should be sent at once to me, The New-walk, Leicester.

May 27th, 1879.

PARIS.

(From a Correspondent.)

M. PÉAN, the well-known surgeon of St. Louis Hospital, has recently performed an operation which has considerably occupied the minds of the medical world in Paris. The patient was a man suffering from cancer of the pylorus, and was, at the time of the operation, in the last stage of cachexia, he not being able to retain any food in his stomach, and having to rely almost entirely on nutritive enemata for sustenance, which, as usual, were found to be insufficient. He accordingly applied to M. Péan to take some operative measures to relieve him, or, if nothing could be done, he was decided, he said, to put an end to his life. M. Péan, rather reluctantly, agreed to comply with the entreaties of the patient and his relatives, and decided to attempt an operation. An incision, about ten centimetres in length, was made on the left side of the umbilicus and parallel to the linea alba. When the peritoneum was opened the stomach was found to be considerably dilated, extending downwards as far as the pubic arch. Its walls were greatly hypertrophied. The peritoneum did not seem to be affected in any great degree. The pyloric portion of the stomach was then gently drawn forwards, when it was found that the growth measured six centimetres transversely and four in a vertical direction. The whole of this mass was excised, as was also a portion of the epiploon, which was diseased. The two surfaces of section were then drawn into contact by means of catgut sutures. No liquid of any kind was allowed to enter the peritoneal cavity during the operation. The abdominal wound was closed in the ordinary manner. The operation lasted two hours and a half. For the first two days after the operation the patient was fed by the rectum, but on the third day some food was allowed to be introduced into the stomach. During the first three days the pulse remained alarmingly weak, consequently it was decided to perform transfusion. Fifty grammes of blood were introduced into the median cephalic vein on a first occasion, and subsequently eighty more were injected. Unfortunately his condition did not improve, and he died on the night of the fourth day. He had shown no signs of peritonitis during these four days. It is much to be regretted that it was not possible to obtain permission to perform a necropsy, as it would have been highly interesting to see what had become of the catgut sutures, and to know whether the intestinal wound showed any signs of uniting.

Until quite lately the physicians who had charge of the wards for the insane in Bicêtre Hospital, as in other establishments of the same kind, had been named by the Prefect of the Seine, but it has been decided recently that these posts should be held up for competition, as in the general hospitals. Two vacancies have occurred at Bicêtre through the death of M. Berthier and the removal of M. Legrand du Saulle to the Salpétrière. These two posts will form the object of a "concours," which is to commence on the 9th of June inst. MM. Legrand du Saulle, Espian de Lamaëstre, Delasiauve, Billod, Devergie, Péter, and Woillez will be the judges. The candidates are eight in number, and among them will be M. Pinel, the grandson of the famous physician of the Salpétrière.

A very promising young student, M. Eugène Pinard, has

met with his death from a dissecting wound which he inflicted upon himself while making a post-mortem examination at St. Louis, at which hospital he was a student. M. Pinard was the brother of the distinguished "agrégé" of obstetrics at the Faculty of Medicine.

By a recent decree of the Minister of the Interior, a third service for female patients suffering from venereal diseases has been formed at the Hospital of St. Lazare. St. Lazare, as most of your readers probably know, is a special hospital, where public women are received, and is in connexion with the Prefecture of Police. Dr. Aime Martin has been appointed to take charge of these new wards, and Dr. G. Oberlin has been named assistant-physician. The Prefect of Police has had the power, up to the present time, of nominating the physicians and "internes" of this establishment, but it is proposed to hold these places up for competition in future.

A new medical journal, called "La Revue Médico-Chirurgicale des Maladies des Femmes," has made its appearance. Dr. Jules Chéron, the head physician of St. Lazare, is the editor. The first number of this new publication came out on the 15th of May.

Professor Gavarret, inspector of faculties, is at the present moment engaged in making a tour through the provinces, paying visits to the several towns where a Faculty has of late been formed.

Paris, June 2nd, 1879.

Obituary.

PROFESSOR PIORRY.

ONE of the most remarkable figures of contemporary medicine in France has just departed this life. He seemed invulnerable, so well did he bear the encroachments of age, and at his advanced time of life he would be seen in the forum of the Paris Academy of Medicine as erect, as firm, and as ardent as ever, fighting his hundredth fight for some favourite theme of medical nomenclature, or some cherished theory in pathology. He has, however, succumbed after a laborious career, full of good work and well-deserved honours.

Piorry was born in 1794, and at the age of 19 began his professional life by following as a student the French troops sent into Spain. He there picked up his first experience of life and medical pursuits, and was prone in his later years to speak with enthusiasm of the exploits of his boyish days. On his return to France he went with great distinction through his curriculum of medical studies, and in various successful contests he gained by public competition the posts of physician to the Paris hospitals and professor at the Paris School of Medicine.

The list of works which he published, from his inaugural thesis "On the danger to Laymen of reading Medical Books" to his latest one "On Common-Sense Medicine" (we believe), would be enough to fill a column of this journal. His most extensive publications were those on a complete system of medical nomenclature borrowed from the Greek, and which, in his idea, was destined to supersede the whole of existing medical appellations. However interesting and justifiable it may have been, it simply served to constitute "Piorry's famous hobby." But his most valuable writings, those which will remain and preserve his name, are his works on "Alterations of the Blood," and especially "Mediate Percussion." What Laennec had done for auscultation, Piorry attempted to do for plessimetrism, and, in his opinion, the results of both methods were equally valuable for the physician, and equally glorious for their authors. There is no doubt that Professor Piorry rendered great service by so earnestly directing the attention of his pupils and the profession to careful study of plessimetry and the valuable information which it affords, and in his writings on mediate percussion many a useful precept may be gathered. Nobody could be more skillful than he was with the ivory plate and the hammer. But he exaggerated evidently both the special value of the instrument and its wonderful results. It was interesting, and, indeed, amusing, to see him in his wards, perched on a high stool, which was taken from bed to bed, and, bent over the patient, now knocking the ivory gently with his hammer, now scarcely grazing it with his fingers, with the conviction and *amore* of some great artist, eliciting marvellous notes from a musical instrument. But in the midst of all this there was much to be learned and worthy to be retained; and although, in addition, he was solemn and authoritative in his teaching, yet his consummate knowledge of medicine, his ardent convictions, his active, inquiring mind and ingenious theories and suggestions, and his complete mastery of the science of physical exploration, made him a remarkable clinical teacher, and at one time his wards were more extensively frequented by foreign medical men and students than any other hospital physician in Paris.

Professor Piorry was versed in general literature and philosophy, and even laid claim to the title of poet. Several of his writings were published in verse, and treated of matters of philosophical speculation. He was not an orator in the true sense of the word, though he commanded a sufficient flow of language, and was biting and sarcastic in his repartees. He was eccentric in his ways and manner, and many are the anecdotes related of his oddities in the *salles de garde des internes*. His ardent "individuality," added to his tall figure and pale intellectual face, made him conspicuous in the medical reunions of the day.

THE LATE DR. MURCHISON.

A GENERAL MEETING was held at Willis's Rooms on Thursday afternoon, under the presidency of Dr. Burdon-Sanderson, for the purpose of organising a memorial of the late Dr. Murchison. Dr. Priestley and Dr. George Harley severally proposed and seconded a resolution to the effect that a Clinical Scholarship or Medal should be the form of the memorial, to be competed for at the University of Edinburgh. Dr. Greenfield (presumably on behalf of a fund that is being organised at St. Thomas's Hospital for a similar purpose) suggested emphatically that the memorial should not be confined to Edinburgh, and having thrown out a hint that perhaps the University of London might be disposed to share the honour, this aspect of the subject was strongly supported by Drs. Burney Yeo and Glover, Mr. Harry Leach, Mr. Lister, Dr. A. P. Stewart, and Mr. Hart, and the following resolution was carried unanimously:—"That a memorial of the late Dr. Murchison be instituted; and that this memorial take the form of a Clinical Scholarship, or a Gold Medal, to be competed for, if practicable, at the Universities of London and Edinburgh alternately."

The names of the committee and officers will be published next week.

Medical News.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on May 29th:—

Cree, Edward Russell, St. John's-park, Highgate.
Culling, John Chislet, Percy-crescent, W.C.
Higson, James, Holly Mount, Blackburn.
Pierson, Alfred Henry, Lee, Kent.
Smith, John, Plumstead.

The following gentlemen on the same day passed the Primary Professional Examination:—

Henry Thomas Hamilton, Charing-cross Hospital; Henry Richard Leech, Queen's Hospital, Birmingham; Thos. Benjamin Lascombe, Guy's Hospital.

ROYAL COLLEGE OF SURGEONS IN IRELAND.—At a meeting of the Court of Examiners held on the 28th ult. and following day, the undermentioned gentlemen were admitted Fellows of the College:—

Cranny, John Joseph. | Porter, Frank Thorpe.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—It appears that the total number of candidates admitted to the primary examination in anatomy and physiology for the membership of the College during the sittings of the Board of Examiners in April and May was 480, and for the fellowship 65. Of the former number 137 were unsuccessful, and of the latter 28.

DR. GEORGE H. KIDD has been elected President of the Irish Medical Association for the ensuing year.

AN examination for degrees in Medicine of the University of Durham will be held at the College of Medicine, Newcastle-upon-Tyne, on the 16th of June and three following days.

THE workmen belonging to fifteen collieries have subscribed no less than £385 17s. on behalf of the Nottingham Hospital. In a time of trade depression this is a handsome donation.

MR. CHARLES P. B. CLUBBE, L.R.C.P. Lond., has been presented with two addresses, a purse of 25 guineas, and a diamond ring, inscribed "From the poor of Kidderminster," on resigning as house-surgeon to the Kidderminster Infirmary.

AT a meeting of the Sanitary Authority of Bristol, Mr. Ashmead, the surveyor, recommended that the sewerage should be carried to an outfall at Charlescombe Bay, between Portishead and Clevedon, a distance of about eight miles, at an estimated cost of £280,000.

PROFESSOR VIRCHOW has returned to Berlin from Asia Minor, where he had examined the excavations of Dr. Schliemann. Great honour was done to him at Athens, where the medical faculty presented to him the diploma of doctor, *honoris causâ*, and the Medical Society elected him honorary member.

THE mortality in London last week was at the rate of 20·6 per 1000 per annum. The deaths registered numbered 1427, and included 8 from small-pox, 80 from measles, 37 from scarlet fever, 7 from diphtheria, 52 from whooping-cough, 12 from different forms of fever, 10 from diarrhœa, 159 from bronchitis, and 93 from pneumonia.

VOTING BY PROXY.—There will be a meeting of the Council of the Royal College of Surgeons on the 12th instant, when the petition from one hundred Fellows, requesting the Council to make such alterations in the bye-laws as will enable the Fellows to vote by proxy or voting-papers at the election of members of Council, will be submitted.

Medical Appointments.

AITKEN, Mr. J., has been appointed Certifying Factory Surgeon for the District of Buckhaven, Fifeshire, vice Robertson, resigned.

BEST, G. P., M.B., M.R.C.S.E., L.S.A.L., has been appointed Resident Surgeon to the Aston Branch of the Birmingham General Dispensary, vice Gosling, resigned.

BOOTH, J. G., L.R.C.P.L., M.R.C.S.E., has been reappointed Medical Officer of Health for the Padiham and Hapton Urban Sanitary District, at £25 for one year, vice Booth, whose appointment has expired.

BROWN, W., L.R.C.P.Ed., M.R.C.S.E., has been appointed Medical Officer for the Caldewgate District of the Carlisle Union, vice Reeves, deceased.

BURNSIDE, G. S., L.R.C.S.I., L.A.H.D., has been appointed Certifying Factory Surgeon for the District of Clondalkin, co. Dublin.

COLLINS, Mr. J. H., has been appointed Public Analyst for the Borough of Helston, at 21s. per quarterly report, and 21s. per analysis.

DALLEY, W. C., M.R.C.S.E., L.S.A.L., has been appointed Certifying Factory Surgeon for the District of Syston, Leicestershire.

DAVIDSON, P. M., L.R.C.P.Ed., L.F.P.S.G., has been reappointed Medical Officer of Health for the Congleton Urban Sanitary District, at £40 per annum.

DUKE, M. S., M.R.C.S.E., L.S.A.L., has been appointed a District Surgeon to the Royal South London Dispensary, vice Smyth, resigned.

ELLIOTT, H., M.R.C.S.E., L.S.A.L., has been appointed House-Surgeon to the Westminster Hospital, vice Arthur, whose appointment has expired.

FALLON, J. S., L.S.A.L., has been appointed Resident Obstetric Assistant to the Westminster Hospital, vice Barnes, whose appointment has expired.

FISHER, C. H., M.D., M.R.C.S.E., has been appointed Medical Officer to the Milton Union Workhouse only (the previous appointment to the Workhouse and the Milton District being rescinded).

FULLER, T., M.D., M.R.C.S.E., has been appointed Certifying Factory Surgeon for the District of New Shoreham, Sussex.

GORST, H., M.R.C.S.E., L.R.C.P.L., has been appointed House-Surgeon to the Liverpool Lying-in Hospital, vice Jenkinson, resigned.

HASSALL, J., M.B., C.M., M.R.C.S.E., has been appointed House-Surgeon to the Stockton Hospital and Stockton Dispensary, vice Smith, resigned.

JAMES, W. C., M.D., has been appointed a Physician to the Westminster General Dispensary, vice Lamb, resigned.

KELLY, Dr. T. J., has been appointed Medical Officer, Public Vaccinator, &c., for the Enniscorthy No. 1 Division of the Enniscorthy Dispensary District, at £100 per annum and fees, and £15 per annum as Medical Officer of Health, vice Goodinson, deceased.

LAWRENCE, H., L.R.C.P.Ed., M.R.C.S.E., has been appointed Medical Officer for the No. 1 District of the Bristol Incorporation of the Poor, vice James, deceased.

MCCALL, Mr. J., has been appointed House-Surgeon *pro tem.* to the Dental Hospital of London, vice Read, resigned.

MAGUIRE, T. S., L.K.Q.C.P.I., L.R.C.S.I., has been appointed Medical Officer of Health for the Potterspury Rural Sanitary District, Northamptonshire, at £45 for one year, vice Haviland, whose appointment has expired.

MARMION, E. J., M.B., has been appointed Medical Officer for the Milton District of the Milton Union, Kent, vice Fisher.

MURPHY, G., L.R.C.P.Ed., M.R.C.S.E., has been appointed Public Vaccinator for the City of Carlisle, Upperby, and Wreay, vice Reeves, deceased.

NAPIER, Mr. J., has been appointed Public Analyst for the Borough of Bury St. Edmunds, at £10 10s. per annum, and 10s. per analysis for the first fifty, and 5s. per analysis beyond in each year, vice Wiggin.

PETTINGER, J. H., M.R.C.S., L.R.C.P., L.S.A.L., has been appointed Assistant Resident Medical Officer to the Manchester Workhouse Hospital.

ROUSE, E., L.R.C.P.Ed., M.R.C.S.E., has been appointed Certifying Factory Surgeon for the District of Bideford, vice Thompson, resigned.

SHEA, J., M.D., M.R.C.S., has been appointed Physician to the Royal Berkshire Hospital, vice Woodhouse, deceased.

STEPHENSON, F. L., M.B., C.M., has been reappointed Medical Officer of Health for the Honiton Urban Sanitary District until the 9th November next.

SWETE, E. H. W., M.D., M.R.C.S.E., has been reappointed Medical Officer of Health for the Droitwich Rural and Urban Sanitary Districts, at £125 and £25 per annum.

THOMPSON, E. M., L.K.Q.C.P.I. & L.M., L.R.C.S.I., has been appointed Surgeon to the Midland Counties Home and Hospital for Chronic and Incurable Diseases, Leamington, vice Leigh, resigned.

WALKER, R., M.D., M.R.C.S.E., has been appointed Medical Officer of Health for the Budleigh Salterton Urban Sanitary District, Devonshire, at £20 per annum.

WILEY, A. O., L.R.C.S.I., L.R.C.P.Ed., has been appointed Acting Surgeon to the 17th West York Volunteers, Knaresborough, vice Houseman, deceased. Also Medical Officer to Knaresborough Odd Fellows Society.

WOOD, W. D., L.R.C.P.Ed., L.R.C.S.Ed., L.S.A.L., has been appointed Medical Officer of Health for the Bicester, Chipping-Norton, Henley, Thame, Witney, and Woodstock Rural, and Bicester, Chipping-Norton, Henley, Thame, Wheatley, and Witney Urban Sanitary Districts, at £616 per annum, till 25th March, 1882, vice Child, whose appointment has expired.

YOUNG, J., M.R.C.S.E., L.S.A.L., has been appointed Certifying Factory Surgeon for the District of Narborough, Leicestershire.

Births, Marriages, and Deaths.

BIRTHS.

BAILEY.—On the 26th ult., at Carlton-road, Nottingham, the wife of Samuel H. Bailey, M.D., of a daughter.

BEVERIDGE.—On the 27th ult., at Dart Villa, Totnes, the wife of H. T. S. Beveridge, Esq., M.D.Ed., Staff-Surgeon, Royal Navy, of a son.

COGHILL.—On the 8th ult., at The Castle, Kandy, Ceylon, the wife of J. D. M. Coghill, M.D., Medical Inspector of the Coffee Districts, of a son.

GREENFIELD.—On the 26th ult., at Palace-road, the wife of William Smith Greenfield, M.D., of a daughter.

LEE.—On the 25th ult., at The Elms, Heckmondwike, the wife of Francis Boynton Lee, F.R.C.P.Ed., of a son.

MACDONNELL.—On the 29th ult., at Dundalk, the wife of Hercules H MacDonnell, M.D., of a son.

MARRIAGES.

DEANE—FISHER.—On the 4th inst., at Sewerby, York, John Deane, M.R.C.S.E., L.R.C.P.Ed., of 42, Albion-road, Stoke Newington, to Alice, elder daughter of the late Rev. John Fisher, of Cossington Hall, Leicestershire.

DRUMMOND—MAY.—On the 27th ult., at the Parish Church, Dronfield, Edward Drummond, M.D., to Rosina, daughter of Henry May, Esq.

FOOT—NAPIER.—On the 3rd inst., at Holkham Church, Norfolk, by the Rev. R. H. Tillard, Rector of Blakeney, Norfolk, assisted by the Rev. Hugh Hare, Vicar of Docking, Robert Herbert Foot, M.D., son of William Foot, Esq., of Dublin, to Helen, daughter of Alexander Napier, Vicar of Holkham.

DEATHS.

BIDDLE.—On the 17th ult., at Yately, Thomas James Biddle, M.R.C.S.E., aged 45.

DUNN.—On the 29th ult., at Birmingham, George Peat Dunn, M.R.C.S.E., of Halesowen.

HOOPER.—On the 28th ult., at Jersey, George Symes Hooper, M.D., aged 79.

KITCHING.—On the 26th ult., at Milnthorpe, John Kitching, M.R.C.S.E., aged 83.

MEDD.—On the 30th ult., at Shrewsbury, John Medd, M.D.

OAKES.—On the 31st ult., at Waterside, Derry, Frederick Ashton Oakes, M.R.C.S.E., Surgeon-Major, Army Medical Department, aged 51.

THOMAS.—On the 24th ult., at Belmont, Twickenham, Ralph Boorder, only child of Owen R. Thomas, L.R.C.P.E., aged 3 years and 6 months.

WILKS.—On the 3rd inst., at Ashford, Kent, George F. Wilks, Esq., M.R.C.S., L.S.A.L., in the 66th year of his age.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

METEOROLOGICAL READINGS.

(Taken daily at 8 a.m. by Steward's Instruments.)

THE LANCET OFFICE, June 6th, 1879.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Wet Bulb	Dry Bulb	Solar Radia in Vacuo	Max. Temp Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
May 30	29·88	S.W.	50	55	97	63	46	..	Cloudy
„ 31	29·67	S.	51	53	98	62	48	..	Raining
June 1	29·63	W.	52	56	92	62	50	..	Cloudy
„ 2	29·60	WNW	50	52	69	58	47	0·43	Raining
„ 3	29·41	N.W.	52	54	98	63	50	0·46	Raining
„ 4	29·36	W.	50	55	104	66	42	0·23	Bright
„ 5	29·90	S.E.	54	59	90	69	46	..	Bright

Notes, Short Comments, and Answers to Correspondents.

TRAINED NURSES IN SCOTLAND.

WE are glad, at the request of the lady superintendent, to call attention to the Association for Providing Trained Nurses for the West of Scotland, established at 220, Sauchiehall-street, Glasgow. This institution has now been in existence for three years. The last annual report shows that during the year ending 31st October, 1878, a total of 326 cases had been treated, 48 of which were puerperal, 108 diseases of women and children, 80 of consumption, and so on. The receipts amounted altogether to £2212, and the chief items of expenditure were £442 for wages of nurses and £323 for household and working expenses. The institution was organised at a public meeting held in March, 1876, and now keeps in constant employment twenty-four nurses, thoroughly trained in hospital work. Mrs. J. S. Higginbotham, the superintendent-general and secretary, informs us that these nurses are at the service of any medical man, either for paying patients and gratuitous work, or for work at a nominal fee. A printed prospectus now before us shows that the rate of remuneration for regular and continuous attendance is fixed at 30s. per week, 20s. extra being paid in infectious cases to provide temporary lodgings for the nurse, "as she cannot be allowed to return to the institution immediately." No gratuities are to be given to these nurses, and no wine or spirits unless by the request of the medical attendant, and twenty-four hours' notice is required when an engagement is about to terminate. In explaining thus briefly the objects and practice of this institution, we cannot, of course, speak with any authority as to the skill of the nurses, or the sources from which they are derived. But those interested in the prosperity of the institution say that it is even now known only to a limited number of medical men in Glasgow and the West of Scotland, so that we are very glad to bring to the notice of our readers the kind of establishment that, if well organised, ought to exist and flourish in every chief city in the United Kingdom.

Dr. W. H. Spencer's paper will be inserted in an early number.

"HARD MASTERS."

To the Editor of THE LANCET.

SIR,—My attention has been called this day to a paragraph in your journal, headed "Hard Masters," by which playful designation you are pleased to describe the Shardlow Board of Guardians in general, and myself in particular. In the first place, allow me to acknowledge the flattering compliment you pay to my supposed influence, which, however, you decidedly exaggerate. You naturally espouse the cause of a member of the medical profession, which, no doubt, highly values your opinion. But I hope you will pardon me for saying it does not appear to me a matter of great importance how you regard the conduct of the Shardlow Board, or of guardians in general, though your language gives us cause to fear that if you did allow your suspended judgment to descend on some of our devoted heads, we should be then and there extinguished.

My ideas of justice to the ratepayers and the poor (and herein, by your own account, I appear to be supported by a majority of the Board, of which I am an humble member) suggest that if B. is unwilling to perform certain duties for a given salary, and W., being duly qualified, is willing, it is the duty of guardians to accept the resignation of B. should he tender it, and to employ the services of W. Nor do I see any hardship in such a course.

Your obedient servant,

Weston-on-Trent, Derby, June 2nd, 1879. JOHN WADHAM.

COLLEGIATE ELECTION.

WE are requested to state that the usual notice of the annual election of Fellows into the Council of the Royal College of Surgeons has been sent to every Fellow in the United Kingdom whose address is known to the Secretary of the College.

L.R.C.P. Ed.—Consult some special work on the Skin.

ANODYNES FOR INFANTS.

THE danger of dosing young children with drugs designed to relieve pain, or at least produce quietness, has been frequently exposed; but it seems necessary again to warn the public, and especially the harassed mothers of large families, against the perils that lurk in powders and potions generally, given with these objects. No drug, so far as we know, exists which has the power of relieving pain or even deadening the sensibility of a child without inflicting some injury on its constitution. The effect produced may be proportioned to the quantity taken; but it is easy to see how even a small dose may be *relatively* too great in any case to escape doing serious harm, even in some cases ending in death. The point for the public is that the pain of toothing and other troubles of infancy cannot be relieved by anodynes. The treatment of these evils must be general and purely professional. To dose a child with narcotics to procure quietness is either a reckless playing with poisons or a crime.

Afflicted should apply to the officials at Guy's Hospital.

ON THE ABOLITION OF CANVASSING AT THE MEDICAL BENEVOLENT COLLEGE.

To the Editor of THE LANCET.

SIR,—It is now somewhat about twenty-seven years since the foundation stone of the Medical Benevolent College at Epsom was laid. I was present at that very interesting ceremony, and became a donor and annual subscriber on my own account, and a donor on behalf of my late wife. I have always felt great interest in this most benevolent and educational institution. Although I have felt such great interest in the objects for which it was founded, yet I was convinced that some points in the administration wanted amendment. *Canvassing* and too great *partiality* in the acts of the Council were the subjects which I disapproved.

On Feb. 9th, 1862, I forwarded two letters for insertion in THE LANCET, one of which was to request the insertion of the copy of a letter which had been sent to the late Mr. Propert, founder of the Medical Benevolent College, in which I condemned the system of canvassing &c. I afterwards withdrew my name as a subscriber.

I have on every occasion, since the period 1862, joined in the efforts made to do away with and for ever abolish the obnoxious and most objectionable system of canvassing. Although my name has not been stated in the recent papers signed by Dr. C. J. Hare and Mr. Hogg, yet I did sign them. Although a great victory has at last been won in crushing the system of canvassing—bad in every aspect,—yet there is room for reflection against the leading members of our profession for allowing this most unjustifiable practice to continue unopposed for so many years. The members of our noble profession too often lose sight of the high Freemasonry principles of brotherhood, and adhere too rigidly to, and adopt, selfish or individual views.

I am, Sir, yours respectfully,

Manchester, May 31st, 1879. THOMAS RADFORD, M.D.

To the Editor of THE LANCET.

SIR,—I see by your last number that a resolution has been carried by a large majority that candidates for the Medical Benevolent College are in future to be recommended by a special committee of selection. Now, although no one knows more than myself of the abuses of the present system of canvassing, I certainly am not prepared for the proposed change. I am quite a new governor of the College, and speak under correction, but I cannot help thinking that the proposed plan of taking the voting power out of the hands of the subscribers at large and vesting it in a special few will make the remedy worse than the disease, and for this reason—that at present the enormous number of voters, widely spread over the whole country, prevents any great abuse, as, although a large amount of pressure by canvassing may be exerted in behalf of a special candidate, yet this is to a great extent neutralised by other centres of similar local pressure. Under the proposed plan, it is intended, it seems, to hand over to a limited few the whole power now exerted by thousands; and although I have no doubt that this power would on the whole be conscientiously exercised, yet we must remember that the selection committee will be composed of "men with like passions to ourselves," and equally liable with others to be amenable to external influences. I do not envy their position, for it must indeed be an invidious task for them so to select as to satisfy all parties that those so selected are more deserving than some of those "left out in the cold." If property "has its duties as well as its rights," the same words apply to power and patronage, and, as a governor possessing my share, I am quite ready, and I hope competent, to exercise such duties without delegating them to others. I am perfectly willing to accept any improvement in the mode of election, but shall utterly refuse the dictation of others in the exercise of my own discretion.

I am, Sir, yours obediently,

June, 1879. A WELL-WISHER TO THE COLLEGE.

R. M.—In Medicine: the work of Bristowe or of F. Roberts. In Midwifery: Playfair or Meadows; Lombe Atthill on Diseases of Women. Roscoe on Chemistry; and Wilson on Hygiene.

Dr. W. H. Boileau.—We are not in the habit of inserting in THE LANCET papers which have appeared in other journals. We must, therefore, decline the letter and tables, with thanks.

Mr. E. A. Jones.—315, Oxford-street, W.

RURAL DELAYS.

WE received this week another illustration of the tardiness too often displayed in rural districts, even where there is urgent need of sanitary reform. There was an outbreak of fever near Bishops Stortford among the persons who inhabited the cottages at Hockerill in 1873, which was generally attributed to the water derived from a well. The water had been proved by analysis to be polluted. It is estimated that £75 would suffice to extend a proper water-supply to these cottages from a neighbouring main. Yet, in spite of all the medical officer could urge, nothing was done, and now there have been two more cases of typhoid fever. Last January the matter was discussed by the Local Board, and this week we are told that it is decided to apply for leave to raise a loan of £75. In the meanwhile the inhabitants still drink the polluted water, still suffer from fever, and six years have now elapsed since this question was first broached.

C. A. S.—It is passing strange that even persons who ought to know better attach undue importance to an occurrence which is in fact not a symptom of disease or even weakness, but an inevitable result of glandular secretion. When the organ becomes full, its contents must needs be discharged. The accumulation of urine in the bladder, particularly if too acid, will excite the other symptoms.

Mr. W. J. Fraser.—We believe that the system adopted by the gentleman named is entirely a matter of education.

Dr. Bramwell.—We shall be glad to see the paper proposed.

MEDICAL MEN AND THE CLERGY.

To the Editor of THE LANCET.

SIR,—It is not often I trouble you with my private opinions on such subjects as fill your "Notes, Comments, and Correspondence" pages; but "M.B.'s" letter, I humbly think, calls for prompt reply.

Like all charity practice, gratuitous advice to the clergy is open to frequent and obvious abuses. It is simply preposterous to suppose, as "M.B." implies, that the example he holds up is worthy of imitation by medical practitioners generally, and I happen to know several men in first-rate practice who recognise no such "long-established and universally acknowledged custom." Fancy a man in such first-rate practice, with eight or a dozen children, attending at the rectory for nothing! The country clergy may perhaps be underpaid. But is the country doctor the man who can afford to attend them gratuitously? Is he so well paid that he can conscientiously give his services at the vicarage? Far from it; the real state of the case is exactly opposite. The rector often, I might say generally, finds plenty of gratuitous work for the doctor, and it is notorious that the doctor gives his services to needy people enough already without sweepingly including the clergy. By the way, who are the "clergy"? ARE they only Church of England parsons, or Methodists, Independents, Blue Lights, No Surrender, Ranters, &c., as well? It would be much more reasonable to attend innkeepers for nothing; for, from a charitable point of view, they appear to be exposed to more health-destroying influences, and, from a selfish or business-like point of view, they provide more sickness for the doctor to attend than any other three or four callings put together. Soldiers, governesses, curates, and numberless poor are already in the doctor's good books. Why on earth the clergy should be swept in wholesale to the private charity I fail to see. The world-famed she-parson is generally an unmitigated nuisance to the practitioner. She keeps a Handbook of Homœopathic Medicine and a few mother tinctures, and physics all her friends in the most charming manner, often surreptitiously whilst the doctor is in attendance; and if the lady requires his services, she will keep him longer in her house, and worry him with more trivial questions, and send for him oftener, than half a dozen other ladies. Each case, of course, must be decided on its merits, and no hard-and-fast rule can be given. Quite lately I attended a rector, who had been ill some three or four weeks, and who had taken aconite, belladonna, arsenicum album, and, for aught I know or care, forty other drugs, under the superintendence of his accomplished wife, and this lady had the calmness to express surprise that her husband got well after two or three (certainly not four) visits. This clergyman has a living of £800 a year, and one daughter to support. Of course, on "M.B.'s" principle, I, with my hardly-earned £800 (out of which I must keep three horses), am to attend this man for nothing!

I regret having taken up so much of your space, Sir; but seeing your liberality so conspicuously proved by the character of some of the effusions in the last part of your estimable and valuable journal, I apologise for my letter, and make bold to ask your favour.

I am, Sir, your obedient servant,

May 26th, 1879. DISCRIMINATION.

YELLOW FEVER.

THE yellow fever is committing terrible havoc at Hayti, and the French Legation at Port-au-Prince has suffered very cruelly from its ravages. M. Waddington on Wednesday received the following melancholy despatch from the Second Secretary:—"M. de Rochechouart, Minister of France, has just died, having been carried away in two hours by an attack of yellow fever. His private secretary has also succumbed, and the first Secretary of Legation as well; and I am experiencing the first attacks of the same malady."

Mr. Samuel Hoseged.—The same gentleman examined the candidates on both occasions for membership and fellowship.

THE WILHELM'S QUELLE WATER.

To the Editor of THE LANCET.

SIR,—I beg leave to enclose you a brief notice of this water, which may be of some use to those who are asked about its properties.

While the public is becoming more and more alive to the dangers which frequently occur from the imbibition of ordinary drinking-water, there is no lack of enterprise in providing a supply of natural and artificial waters for the table. Some of these latter are prepared from the waters supplied by the Companies, and which are known to contain a considerable amount of organic matter; and these are more objectionable than the original water itself, because, the access of air being prevented, the natural purification of the water by free exposure is not only prevented, but putrefactive change is encouraged. It is due to some makers to state that their artificial waters are prepared from distilled water.

The use of bottled water is now so general that it is necessary the medical practitioner should make himself acquainted with the characters of those which are brought before the public. A few words about the Wilhelm's Quelle Water, which is rapidly and deservedly becoming popular, will therefore perhaps not be out of place in your columns. It comes under the class of "Alkaline Sparkling Waters." The Wilhelm Quelle is no new discovery. It was renowned as "the old Sanerborn" in the sixteenth century, and gave its name to the valley of the Kronthal, out of which it springs, and which is not far distant from Frankfort-on-the Maine. According to a recent analysis by Professor Fresenius, the composition of the water is as follows—in 1000 parts by weight:

	Per Mille.
Chloride of sodium	1·890965
Chloride of potassium	0·086578
Sulphate of potassium	0·023632
Bromide of sodium	0·000641
Iodide of sodium	0·000010
Phosphate of sodium	0·000954
Carbonate of sodium	0·051037
Carbonate of lithium	0·003539
Carbonate of barium	0·000585
Carbonate of strontium	0·002019
Carbonate of lime	0·418338
Carbonate of magnesia	0·090472
Carbonate of iron	0·029575
Carbonate of manganese	0·002368
Silicic acid	0·101090
	2·457753
Carbonic acid combined with certain carbonates to form bicarbonates	0·270724
Free carbonic acid	2·249736
Total per mille	4·978163

Temperature of the water at the spring = 13·54° Celsius, or 56·21° F.

The water is highly charged with carbonic acid, and that which escapes on rising to the surface is collected, and again compressed into the water, as it is bottled at the spring. It is a remarkably bright and pleasant water, of an agreeable saline flavour, more delicate than either Seltzer or Appolinaris, owing to the much smaller proportion of sulphates. These physical characters are associated with a chemical constitution such as renders the water admirably suited for table use, as the above analysis well shows. Indeed, of all mineral waters, there is none which in respect of the proportion of saline constituents so closely resembles the blood. Thus, bulk for bulk, the proportion of chlorides is about half those of blood, and about the same as those of milk, and they are just sufficient to elicit and strengthen the bouquets of the more delicate wines. The quantity of iron is less than half that of blood, and it exists in the same form—viz., carbonate of the protoxide. The proportions of sulphates and of phosphates are less than those of blood; but even in respect of these, as well as of iron, the water may evidently be considered as a natural restorer of the essential saline constituents of the blood. Regarded from a medicinal point of view, we note traces of iodide and bromide of sodium and of carbonate of lithium; while the presence of a moderate amount of the carbonates of sodium, of calcium, and of magnesium confer antacid properties.

I remain, Sir, yours faithfully,

Brook-street, May, 1879. JOHN HARLEY.

ANTI-VIVISECTION AGITATION IN THE PROVINCES.

WE are glad briefly to call attention to a very capital speech made by Dr. T. J. Walker at Peterborough some few days ago. At an anti-vivisection meeting, called together by a person sent down from London for the purpose, certain resolutions were proposed condemnatory of the practice of performing operations on living creatures for scientific purposes. But Dr. Walker at the end of the address rose, and so completely cut the ground from under the feet of the lecturer that he carried an amendment against the principles advocated by that individual by a very large majority.

M.D.—Dr. Tilt has written a book specially on Change of Life; but the diseases proper to this crisis are treated of more or less in all works on Diseases of Women.

A Sufferer (C. S. L. G.)—We know nothing of the merits of patent medicines, nor do we prescribe. A qualified medical practitioner should be consulted in the case.

Mr. C. H. Matthews.—The information required will be found in the Students' Number of THE LANCET, Sept. 14th, 1878.

MR. JUSTICE STEPHEN ON HOSPITALS.

MR. JUSTICE STEPHEN presided last week at a dinner held in the Hall of the Inner Temple on behalf of King's College Hospital, at which about 350 persons were present. The Chairman, in proposing the toast of the evening, "Success to the Hospital," alluded felicitously to the sympathy that exists between law and medicine, commenting upon the fact that in this case they were not only friends but neighbours, the hospital and the new Law Courts being close companions. He concluded an able speech by paying a high compliment to the members of the nursing establishment, and mentioned also particularly the advantages derived from the acquisition of a convalescent home at Hemel Hempstead.

THE M.D. OF BRUSSELS.

To the Editor of THE LANCET.

SIR,—I observe in the notice of the M.D. degree of Brussels, in your issue of May 24th, that you consider the examination below that required for the L.R.C.P. Lond. Having passed both examinations, I can state, without hesitation, that the examination for the M.D. Brussels is very much more searching and complete than that of the London College of Physicians. The examiners limit themselves to no time, but question you as long as they think proper, and they do not leave whatever disease or subject they commence examining upon until they have completely exhausted it. In pathology they are particularly minute, and indeed in every part of the examination they are most thorough and exacting, and I am sure that no one who is not well up in his subjects has any chance of obtaining the degree. In proof of this I may mention that out of eight candidates who presented themselves in the same month as I did in 1877, six failed to obtain the degree. My experience of this examination leads me to believe that, with the exception of the University of London, there is no examination in Great Britain in medical subjects equal to it in severity and thoroughness.

I am, Sir, your obedient servant,

St. Albans, May 20th, 1879. RICHARD HY. PRIOR.

To the Editor of THE LANCET.

SIR,—In your journal of the 24th inst. you say there is no impropriety in using the Brussels M.D. degree as a title. Will you permit me to point out that, as all British University degrees are supposed to issue from the sole fountain of honour recognised in this country—that is, the Sovereign, who, in the case of Universities (as is also now done in the army and navy), has put her powers into Commission, it is really illegal to assume, as a title, a degree obtained from any foreign University without the sanction of the Sovereign or the Commission appointed by her (in this case the General Medical Council) to regulate such matters. A Count of the Holy Roman Empire or an Austrian Baron, being a British subject, is prohibited by the Foreign Titles Act from assuming or wearing such title, and is denied any precedence therefrom—is, in fact, a plain "Mr. ——," unless by special permission. Although University degrees are perhaps smaller matters, yet the rule is the same.

While on this subject, I may say that I think it a pity that those medical men who aspire to a University degree do not seek to enter the temple of honour in a legitimate manner by qualifying for the M.D. of Durham. This University has very properly, I think, provided for the requirements of those really able and deserving practitioners who require, after the experience of years, to receive an official *imprimatur*, by establishing a special examination, which, while it does not pretend to equal the training involved in a University residence, yet is sufficiently searching and difficult to render the M.D. degree so granted a truly honourable distinction.

The University of St. Andrews also grants *ten* such degrees every year, and a reference to its graduation roll would disclose the names of many distinguished practitioners. Yours truly,

Edinburgh, May 27th, 1879. AN HERALDIC M.D.

*** The Medical Council has no such function at present as our correspondent seems to think it has. We agree with him in preferring British degrees; but we see no impropriety in using the degrees of foreign countries, *explicitly*, and for what they are worth.—ED. L.

M. B.—Logic: Jevons' Elementary Lessons; Fowler's Inductive Logic; and Mill's Logic. Psychology: Bain's Senses and Intellect, and Emotions and Will.

M.R.C.S. and L.R.C.P.—The preparations in question are new remedies, and one of them is patented. We are not prepared to express any opinion on their therapeutic virtues.

THE CASE OF THOMAS MILLERCHIP.

To the Editor of THE LANCET.

SIR,—There is a general consensus of opinion among members of the profession and others I have either met or corresponded with, that a most cruel act of injustice was perpetrated in sentencing this diseased and most unfortunate man to imprisonment and hard labour. The General Medical Council marked their sense of the procedure by deciding to retain his name on the Register, although, under Lord Justice Coleridge's ruling, he was found guilty of manslaughter. His term of imprisonment is drawing to a close; but he will want help to enable him to make a fresh start in life. If any gentleman will kindly send me a subscription, I will take care to see that it be utilised for his benefit.

I am, Sir, yours obediently,

35, Dean-street, Soho, June 4th, 1879. JOSEPH ROGERS.

CASUAL WARDS.

We have already remarked that complaints have been made by the Metropolitan Board of Works concerning the condition of the casual wards of St. George's-in-the-East. To this the guardians have replied that the wards were cleansed every twelve months, and in three months hence the year will have expired, and the cleaning will be done! This is surely a most unsatisfactory reply. According to the Act of 1851, common lodging-houses have to be re-whitewashed twice a year, in the spring and in the autumn, and the precautions necessary at these low lodging-houses must also be required in casual wards, where the frequenters are of even a worse type. We might also expect the local authorities to set an example of cleanliness; but experience has taught us that this is scarcely to be anticipated at St. George's-in-the-East.

Mors.—We are decidedly of opinion that such steps would not be in good taste, and that our correspondent should act as if he were an entire stranger.

PORTSMOUTH BOROUGH ASYLUM.

To the Editor of THE LANCET.

SIR,—In a late number of THE LANCET you animadverted somewhat strongly on the behaviour of the Committee of Management of the Portsmouth Borough Asylum when deciding on the amount of salary &c. to be offered to the medical superintendent, and, as one of the candidates for the appointment, I should be glad if you would allow me to detail my experience with them.

At first canvassing was presumably not allowed, as it was impossible to get a list of the Committee, even for the purpose of sending a copy of testimonials to each. A few days before the date fixed for seeing the candidates, a circular was sent round the County Asylum, giving the names not only of the Committee, but of the Town Councillors, with whom, it seems, the appointment rests. I visited Portsmouth, saw several of the electors (small chemists, retail tradesmen, pastry-cooks, &c.), was thoroughly disgusted with the whole system upon which the election was to be conducted, and returned to my home a sadder and, I hope, a wiser man. I heard when in Portsmouth that a general practitioner of the town had been promised upwards of two-thirds of the votes, and if this be so, no one, not even the most disappointed candidate, can envy him when he thinks of what must have been gone through to get these promises. Eight candidates have been elected for further consideration. The majority of these are men who have been but a few years in the specialty, and only one, or at the most two, are at all known to their *confrères*, while several of ten years' asylum experience and upwards have been rejected altogether. It would seem that not one of the candidates who failed to canvass got his name on the select list. I believe this is the only asylum appointment taking place within the last ten or fifteen years for which canvassing has been permitted, and to place a responsible medical post in the hands of the Town Council of Portsmouth is surely too much of a burlesque to need comment. If it be correct that one of the candidates has been promised a majority of the votes, would it not be more becoming for the others to withdraw their names from the competition?

I am, Sir, your obedient servant,

May 29th, 1879. NON LIBET.

POISONOUS WALL-PAPERS.

THE full extent of the peril attending the use of arsenical wall-papers is not yet, it would seem, realised. It is startling to find that surprise has been excited by the statement that not only green but other brightly coloured papers contain arsenic. As a matter of fact, we believe that mineral substances form an integral part of many colouring matters extensively employed, and, while needless or at least avoidable, their presence is to be suspected in most papers which have not been prepared with a special view to health; hence the need of unusual precautions.

"A GRIEVANCE: A VERY GREAT ONE."

To the Editor of THE LANCET.

SIR,—In your last issue there appears a letter from Dr. Ritchie under the above heading, and, as far as my experience goes, the treatment he complains of is no uncommon occurrence at the hands of our county coroners. The statements contained in his letter vividly call to my mind a parallel case which happened to myself a few years since whilst practising in Norfolk.

Similar to your correspondent, Dr. Ritchie, I had to drive two miles, and lose the whole of the afternoon, in order to ascertain what was to be done with the body of a poor labouring lad which had been discovered in a field. I took the trouble to gather all the necessary particulars, and sent notice of the death to the coroner by the village constable. Much to my surprise, the coroner, instead of summoning me as a witness, requested another practitioner (who resided at least four miles from the inn where the inquest was held) to make the post-mortem and give the necessary evidence, myself, who had all the trouble and annoyance, being totally ignored.

I am much afraid Dr. Ritchie's good intentions with regard to warning the medical profession against any mal-treatment received at the hands of coroners will be fruitless.—Yours faithfully,

E. A. PIGGOTT, L.R.C.P. & S. Edin., &c.

Shepherd's-bush, June 2nd, 1879.

QUESTION OF MEDICAL CHARGES.

Non time agere merito.—The charges for medical and obstetric services are very reasonable. We have long thought it undesirable for practitioners to make any charge for medicines. They are supposed to be paid for their services and their opinions rather than their drugs. The Medical Act gives a medical practitioner the power to demand and recover in any court of law, with full cost of suit, reasonable charges for professional aid, advice, and visits, and *the cost* of any medicines or other medical or surgical appliances rendered or supplied by him to his patients.

RESIDENT MEDICAL OFFICER TO CHARTERHOUSE.

Inquirer asks to be informed of the emolument attached to the above appointment, and whether it is restrictive.

P. M. P.—Our correspondent has great reason to complain. The conduct he describes—supposing his description to be a correct one—is extremely reprehensible. It is questionable whether our correspondent should not take steps, in a very clear case, to protect himself; but in the meantime we think he should make a careful representation of his grievance to those of whose conduct he has so much right to complain.

L.R.C.P., (Derbyshire.)—According to the statement of the case submitted to us, there does not appear to be any ground of action, and the profession is helpless in the matter.

F.R.C.S.—Monday next will be the latest day for sending in nominating-papers of candidates for seats in the Council of the College of Surgeons.

CASE OF OBSTINATE CONSTIPATION.

To the Editor of THE LANCET.

SIR,—Will any of your readers kindly favour me with their opinion as to the best means of treatment for a case of most obstinate constipation, dependent upon the following combination of circumstances, which renders the use of almost all the usual purgatives impossible?

There exists a greatly thickened and contracted state of the transverse colon, consequent upon ulceration and acute dysentery many years since. The contraction has been slowly increasing, but there has also supervened for some months so irritable a state of the mucous membrane that when a purgative is taken, tenesmus, discharge of mucus, and great depression follow. When the bowels are confined the intestinal flatulence is persistent and most distressing.

Any hint as to the management of the above—for which almost everything in the shape of drug and dietary has been tried in vain—will be gratefully appreciated by THE SUFFERER.

Brighton, June 3rd, 1879.

COMMUNICATIONS, LETTERS, &c., have been received from—Dr. Buzzard, London; Dr. Maclagan, London; Dr. McCall, Andersen, Glasgow; Dr. Hall Davis, London; Dr. Wilks; Dr. Rogers; Mr. Murrell, London; Dr. Cottle, London; Mr. Wilson, Manchester; Dr. D. Hooper, London; Mr. Kelly, London; Dr. Duncan, London; Mr. Brodhurst, London; Mr. Piggott, London; Dr. Freer, Rugeley; Mr. Dobson, Aberdeen; Mr. Letcher, Kentucky; Mr. Lewtas, India; Mr. Wilson, Oundle; Dr. Boileau, Woolston; Mr. Armstrong, Newcastle; Dr. Lowson, Huddersfield; Mr. Emmerson, Waltham; Provost Leslie, Nairn; Dr. Greene, Mallow; Surgeon-Major Curran, Warrington; Dr. Hoggan, London; Mr. Alexander, Liverpool; Mr. Brown, Leeds; Mr. Vance, Plaistow; Mr. Richmond, Warrington; Mr. Bartlett, Birmingham; Dr. Radford, Manchester; Mr. Hosegood, Swinton; Mr. Wiley, Knaresborough; Mr. Deakin, Allahabad; Mrs. Higginbotham, Glasgow; Dr. Carter, Bombay; Mr. Townsend, Exeter; Mr. B. Rugg, Wood-green; Dr. Best, Kilburn; Dr. M'Clure, Chadwell Heath; Mr. Matthews, Bradford; Dr. Browne; Dr. Tatham; Dr. Moore, Coventry; Mr. Hunter; Mr. H. Fox; Dr. M'Munn; Dr. Fraser, Ashburton; Dr. Bramwell, Perth; Rev. J. Wadham, Weston-on-Trent; Dr. Elliott, Bristol; Mr. Hamilton, Washington, U.S.A.; Mr. Roberts, Bradford; Mr. Hackett; Mr. Smith; Mr. T. Cooke; Dr. Pettinger, Manchester; Dr. Gorst, Liverpool; Dr. Jones, Kingsland; Mr. Green; Dr. Spencer, Clifton; Mr. Campbell; Mr. Newman; Mr. Hinds, Hoxton; Messrs. Green and Co.; Mr. Gurner; Mr. Cornby, Newbury; Dr. Beveridge, Totnes; Mr. Wilkinson; Mr. Howells; Dr. Dolan, Halifax; Dr. D. R. H.; A Well-wisher to the College; Non Libet; Norwegian; *&c. &c.*

LETTERS, *each with enclosure*, are also acknowledged from—Dr. Wallace, Cardiff; Dr. M'Naughton, Blackpool; Mr. Fagge, Lutterworth; Mr. Kinder, Leicester; Mrs. Miller, Portsmouth; Dr. Davies, Ebbw Vale; Mr. Loy, Northallerton; Mr. Kemm, Corsham; Mr. Foote, Rotherham; Mr. Phillips; Mr. Boyd; Dr. Osborn, Bradford; Dr. Aitken; Dr. Lee, Heckmondwike; Mr. Ashworth; Dr. Archer, Omagh; J. L.; Hector; D. R. H., Hurstmonceux; Vicar; Smith, Leeds; Delta; A. B., Kentish-town; G., Bristol; Faith; Lady Superintendent; J. M.; M.D., Rotherhithe; A. B. C., Cardiff; F.R.C.S. Edin.; R. S.; X. Y. Z., Newcastle; Tutor; Alpha, Newcastle; J. W.; M., Edinburgh; M.D., St. Ives; E. R., Maldon; A. B., Braintree; W., Ashworth; T. S. F.; E. H. L.; W. R. S., Dublin; A. H., Kensington; A. B. C.; X. Y. Z.

Daily Exchange, Vaccination Inquirer, Cheltenham Examiner, Glasgow Herald, Nottingham Evening Post, Kidderminster Times, Nottingham Daily Guardian, Royal Leamington, Warwick, and County Chronicle, North British Daily Mail, Sun, &c., have been received.

Medical Diary for the ensuing Week.

Monday, June 9.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.
ST. MARK'S HOSPITAL.—Operations, 2 P.M., and on Tuesday at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Mr. Benjamin T. Lowne, "On the Physiology of Sensation."

Tuesday, June 10.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 3 P.M.
ROYAL INSTITUTION.—3 P.M. Professor Karl Hillebrand, "On the Intellectual Movement of Germany from the Middle of the Last to the Middle of the Present Century."
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8 P.M. Ballot.—8½ P.M. Dr. Gowers, "On the Movements of the Eyelids."—Dr. Garlick, "On the Ophthalmoscopic Appearances in the Tubercular Meningitis of Children."—Mr. Sampson Gamgee: "Case of Abscess of the Brain."—Mr. John Gay: Removal of Cancerous Stricture of the Rectum."—Mr. Howse will present two Patients after recovery from Gastrostomy.

Wednesday, June 11.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. MARY'S HOSPITAL.—Operations, 1½ P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
KING'S COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at 1 P.M.
LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.
GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Sat[urday] at the same hour.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Op[erations] 2½ P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Profess[or] Hutchinson, "On the Influence of the Nervous System [in the] duction of Disease, chiefly with reference to the Sk[in] Joints."
ROYAL MICROSCOPICAL SOCIETY.—8 P.M. Professor Abbe: "[On] of Correcting Spherical Aberration"; Professor Abbe [will] hibit his Apparatus for demonstrating on a large s[cale] mental experiment of the theory of Microscopic Vision [by] Wenham: "Note on Professor Abbe's Apertometer." "On the Theory of Illuminating Apparatus employ[ed] Microscope."

Thursday, June 12.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultation.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., [and on] Friday at the same hour.
ROYAL INSTITUTION.—3 P.M. Professor Karl Hillebrand, "On the Intellectual Movement of Germany from the Middle of the Last to the Middle of the Present Century."

Friday, June 13.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.
ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor Jonathan Hutchinson, "On the Influence of the Nervous System in the Production of Disease, chiefly with reference to the Skin, Eye, and Joints."
ROYAL INSTITUTION.—9 P.M. Mr. F. J. Bramwell: "The 'Thunderer' Gun Explosion."

Saturday, June 14.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

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N.B.—All letters relating to Subscriptions or Advertisements should be addressed to the Publisher.

Gulstonian Lectures
ON
THE LYMPHATIC SYSTEM AND ITS DISEASES.

Delivered at the Royal College of Physicians, March, 1879,

BY JOHN CURNOW, M.D., F.R.C.P.,
PROFESSOR OF ANATOMY IN KING'S COLLEGE, AND ASSISTANT-PHYSICIAN TO KING'S COLLEGE HOSPITAL.

LECTURE III.—PART III.

THE LYMPHATIC SYSTEM OF THE HEAD AND NECK.

THE lymphatic glands of the *head* are not very numerous, and may be thus classed into groups :—

1. The suboccipital (one, or occasionally two), near the insertion of the complexus, receiving the lymphatics from the back of the occiput.

2. The mastoid, four or five in number, receiving the efferent vessels from the above glands.

3. The parotid. These are more numerous, and are placed beneath the parotid fascia. From two to four are tolerably superficial in the substance of the gland, whilst others (three to six) are very deep. The largest is a superficial gland in front of the tragus, whilst many are very small. The lymphatics from the orbits, nose (posteriorly), upper jaw, upper part of pharynx and cranium, through the foramen [illegible]osum, pass into these.

[illegible]he submaxillary. These are arranged under the [illegible]ria along the base of the lower jaw, and are from [illegible]een in number.

[illegible]a-hyoid : one or two in the median line of the [illegible] the hyoid bone and the chin. I saw these en- [illegible]weeks ago in a case in which there was a [illegible]o the inside of the lower lip in the median [illegible]eeks afterwards, coincident with ulcerations [illegible]nd back of the tongue, the submaxillary and [illegible] became affected.

[illegible]t vessels from all these groups pass into the [illegible]d glands.

[illegible]phatics of the mucous surface of the tongue are [illegible]erous, the networks being principally along the [illegible] of the dorsum and the posterior extremities of its [illegible]ers. The median network is most developed in the neighbourhood of the circumvallate papillæ. In the fœtus they extend forward to the tip, but in the adult few are found in front of the junction of the anterior and middle thirds. Every papilla is surrounded by a complete ring of lymphatic vessels, and from this ring they run up on the surfaces of the papillæ, and form a sheath superficial to the capillary plexus.

The vessels which emerge from the dorsal plexus are directed both forwards and backwards. The most anterior from the tip pass between the muscular fibres, are joined by deep vessels (intermuscular), and terminate in the supra-hyoid glands; the others pass to a gland near the sides of the thyroid cartilage. The posterior trunks are four in number; two of them pass through the superior constrictor of the pharynx, and two through the thyro-hyoid membrane, to terminate in the deep cervical glands.

The glands of the *neck* form a chain which extends downwards under the sterno-mastoid muscle from the parotid and mastoid groups to the subclavian and mediastinal. Most of them surround the jugular veins, and when enlarged increase towards the pharynx and œsophagus. They are best divided into superficial and deep groups. The superficial are in a line with the external jugular vein. These are from four to six in number beneath the platysma, but superficial to the sterno-mastoid muscle. They receive vessels from the auricle, the cutaneous surface of the head and neck, and part of face, besides the efferent vessels from the mastoid and some of the submaxillary glands. The deep group must be distinguished as superior and inferior. The former are from ten to sixteen in number, and are placed near the bifurcation of the common carotid artery and along the internal jugular vein. They receive efferent vessels from the parotid and some of the submaxillary glands from the tongue, palate, larynx, lower part of the pharynx, the deep muscles of the head and neck, and from within the cranium. The latter, fewer and smaller, are placed in the supra-clavicular fossa, in relation with the scaleni muscles and the brachial plexus of nerves. They receive efferent vessels from the superior glands, both superficial and deep, and the lymphatics from the lower part of the neck. They communicate with the axillary and mediastinal glands, and so may be infected in succession from either direction. Between the superior and inferior groups are two or three small connecting glands, which have been called the deep median group.

1. A very fine network of lymphatics is found in the mucous membrane of the gums and hard palate, and the vessels are large both in the median line and posteriorly. The vessels from the lower gums open into the submaxillary glands; whilst those from the hard palate join the vessels of the soft palate.

2. The soft palate is contained in a sheath of lymphatics, continuous with those of the nasal fossæ and of the hard palate. The network on the lower surface is especially well marked, and that on the uvula is extraordinary. The trunks which emerge may be divided into anterior, median, and posterior. The anterior join with those from the base of the tongue and hard palate, and end in glands around the lower part of the internal carotid; the median group divides into a right and left, which are joined by those from the tonsils, and pass to the glands on a level with the hyoid; whilst the posterior run along the posterior pillars of the pharynx to glands near the bifurcation of the common carotid.

3. The lymphatics of the pharynx begin in a network beneath the mucous membrane, and leave it as four groups: the upper two to converge to the retropharyngeal gland in front of the axis, and the lower two to end in the glands on a level with the upper part of the thyroid cartilage.

4. The lymphatics of the larynx and trachea are especially numerous at the upper aperture, and are spread all along the arytæno-epiglottidean folds. They cover both surfaces of the epiglottis, and are found throughout the larynx and trachea beneath the mucous membrane, but are not nearly so numerous elsewhere as in the position above mentioned. The vessels emerge from the upper part through the thyro-hyoid membrane, and join glands on a level therewith; whilst others pass at various points into the glands near the tubes.

5. Lymphatics of the thyroid body are described by Haller, Hunter, and Mascagni, and, according to the latter authority, arise from the hollow surfaces in its interior, and pass into the cervical glands. Sappey denies their existence.

On the descriptive anatomy of the thoracic duct and right lymphatic trunk I need not dwell. The former begins on the second lumbar vertebra by five radicles; two of these ascend from the lower extremities, pelvic organs, kidneys, and large intestine; two descend from the lower eight intercostal spaces, and the hinder part of the diaphragm. These are the important anastomotic trunks by which the fluid sometimes passes after ligature of the duct, but in a direction opposite to the normal current. They recall the azygos system of veins. The fifth is an anterior vessel, common to the small intestines, liver, stomach, spleen, and pancreas, and is often termed the intestinal trunk. In its course along the spine the duct receives only very few tributaries, and these are quite unimportant, except for purposes of anastomosis. On its emergence from the chest, the vessels of the left lung and left side side of heart, the left half of the thoracic and abdominal walls, from the left side of the head and neck, and from the left upper extremity, enter as three large vessels—inferior, superior, and external respectively, and it terminates at the junction of the left subclavian and internal jugular veins. Three large vessels from the right side of the head and neck, from the right upper extremity, and from a part of the right lung, heart, diaphragm, and convexity of the liver, converge, and form the right lymphatic trunk. This is from a quarter to half an inch long, and ends at the corresponding site on the right side.

Anomalies in the course and termination of the thoracic duct are well known. Wutzer, in Müller's *Archiv* for 1834, has described it as terminating in the vena azygos major by two branches, and Arnold has met with a similar case. It often ends by more branches than one, as Lower pointed out in 1728, and he in fact considered this to be the rule.

QUESTION OF MEDICAL CHARGES.

Non times opere merito.—The charges for medical and obstetric services are very reasonable. We have long thought it undesirable for practitioners to make any charge for medicines. They are supposed to be paid for their services and their opinions rather than their drugs. The Medical Act gives a medical practitioner the power to demand and recover in any court of law, with full cost of suit, reasonable charges for professional aid, advice, and visits, and *the cost* of any medicines or other medical or surgical appliances rendered or supplied by him to his patients.

RESIDENT MEDICAL OFFICER TO CHARTERHOUSE.

Inquirer asks to be informed of the emolument attached to the above appointment, and whether it is restrictive.

P. M. P.—Our correspondent has great reason to complain. The conduct he describes—supposing his description to be a correct one—is extremely reprehensible. It is questionable whether our correspondent should not take steps, in a very clear case, to protect himself; but in the meantime we think he should make a careful representation of his grievance to those of whose conduct he has so much right to complain.

L.R.C.P., (Derbyshire.)—According to the statement of the case submitted to us, there does not appear to be any ground of action, and the profession is helpless in the matter.

F.R.C.S.—Monday next will be the latest day for sending in nominating-papers of candidates for seats in the Council of the College of Surgeons.

CASE OF OBSTINATE CONSTIPATION.

To the Editor of THE LANCET.

SIR,—Will any of your readers kindly favour me with their opinion as to the best means of treatment for a case of most obstinate constipation, dependent upon the following combination of circumstances, which renders the use of almost all the usual purgatives impossible?

There exists a greatly thickened and contracted state of the transverse colon, consequent upon ulceration and acute dysentery many years since. The contraction has been slowly increasing, but there has also supervened for some months so irritable a state of the mucous membrane that when a purgative is taken, tenesmus, discharge of mucus, and great depression follow. When the bowels are confined the intestinal flatulence is persistent and most distressing.

Any hint as to the management of the above—for which almost everything in the shape of drug and dietary has been tried in vain—will be gratefully appreciated by THE SUFFERER.

Brighton, June 3rd, 1879.

COMMUNICATIONS, LETTERS, &c., have been received from—Dr. Buzzard, London; Dr. Maclagan, London; Dr. McCall, Anderson, Glasgow; Dr. Hall Davis, London; Dr. Wilks; Dr. Rogers; Mr. Murrell, London; Dr. Cottle, London; Mr. Wilson, Manchester; Dr. D. Hooper, London; Mr. Kelly, London; Dr. Duncan, London; Mr. Brodhurst, London; Mr. Piggott, London; Dr. Freer, Rugeley; Mr. Dobson, Aberdeen; Mr. Letcher, Kentucky; Mr. Lowtas, India; Mr. Wilson, Oundle; Dr. Bolleau, Woolston; Mr. Armstrong, Newcastle; Dr. Lawson, Huddersfield; Mr. Emmerson, Waltham; Provost Leslie, Nairn; Dr. Greene, Mallow; Surgeon-Major Curran, Warrington; Dr. Hoggan, London; Mr. Alexander, Liverpool; Mr. Brown, Leeds; Mr. Vance, Plaistow; Mr. Richmond, Warrington; Mr. Bartleet, Birmingham; Dr. Radford, Manchester; Mr. Hosegood, Swinton; Mr. Wiley, Knaresborough; Mr. Deakin, Allahabad; Mrs. Higginbotham, Glasgow; Dr. Carter, Bombay; Mr. Townsend, Exeter; Mr. B. Rugg, Wood-green; Dr. Best, Kilburn; Dr. M'Clure, Chadwell Heath; Mr. Matthews, Bradford; Dr. Browne; Dr. Tatham; Dr. Moore, Coventry; Mr. Hunter; Mr. H. Fox; Dr. M'Munn; Dr. Fraser, Ashburton; Dr. Bramwell, Perth; Rev. J. Wadham, Weston-on-Trent; Dr. Elliott, Bristol; Mr. Hamilton, Washington, U.S.A.; Mr. Roberts, Bradford; Mr. Hackett; Mr. Smith; Mr. T. Cooke; Dr. Pettinger, Manchester; Dr. Gorst, Liverpool; Dr. Jones, Kingsland; Mr. Green; Dr. Spencer, Clifton; Mr. Campbell; Mr. Newman; Mr. Hinds, Hoxton; Messrs. Green and Co.; Mr. Gurner; Mr. Cornby, Newbury; Dr. Beveridge, Totnes; Mr. Wilkinson; Mr. Howells; Dr. Dolan, Halifax; Dr. D. R. H.; A Well-wisher to the College; Non Libet; Norwegian; &c. &c.

LETTERS, *each with enclosure*, are also acknowledged from—Dr. Wallace, Cardiff; Dr. M'Naughton, Blackpool; Mr. Fagge, Lutterworth; Mr. Kinder, Leicester; Mrs. Miller, Portsmouth; Dr. Davies, Ebbw Vale; Mr. Loy, Northallerton; Mr. Kemm, Corsham; Mr. Foote, Rotherham; Mr. Phillips; Mr. Boyd; Dr. Osborn, Bradford; Dr. Aitken; Dr. Lee, Heckmondwike; Mr. Ashworth; Dr. Archer, Omagh; J. L.; Hector; D. R. H., Hurstmonceux; Vicar; Smith, Leeds; Delta; A. B., Kentish-town; G., Bristol; Faith; Lady Superintendent; J. M.; M.D., Rotherhithe; A. B. C., Cardiff; F.R.C.S. Edin.; R. S.; X. Y. Z., Newcastle; Tutor; Alpha, Newcastle; J. W.; M., Edinburgh; M.D., St. Ives; E. R., Maldon; A. B., Braintree; W., Ashworth; T. S. F.; E. H. L.; W. R. S., Dublin; A. H., Kensington; A. B. C.; X. Y. Z.

Daily Exchange, Vaccination Inquirer, Cheltenham Examiner, Glasgow Herald, Nottingham Evening Post, Kidderminster Times, Nottingham Daily Guardian, Royal Leamington, Warwick, and County Chronicle, North British Daily Mail, Sun, &c., have been received.

Medical Diary for the ensuing Week.

Monday, June 9.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.
ST. MARK'S HOSPITAL.—Operations, 2 P.M., and on Tuesday at the same hour.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Mr. Benjamin T. Lowne, "On the Physiology of Sensation."

Tuesday, June 10.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 3 P.M.
ROYAL INSTITUTION.—3 P.M. Professor Karl Hillebrand, "On the Intellectual Movement of Germany from the Middle of the Last to the Middle of the Present Century."
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8 P.M. Ballet.—8½ P.M. Dr. Gowers, "On the Movements of the Eyelids."—Dr. Garlick, "On the Ophthalmoscopic Appearances in the Tubercular Meningitis of Children."—Mr. Sampson Gamgee: "Case of Abscess of the Brain."—Mr. John Gay: Removal of Cancerous Stricture of the Rectum."—Mr. Howse will present two Patients after recovery from Gastrostomy.

Wednesday, June 11.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. MARY'S HOSPITAL.—Operations, 1½ P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
KING'S COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at 1 P.M.
LONDON HOSPITAL.—Operations, 2 P.M., and on Thursday and Saturday at the same hour.
GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor Jonathan Hutchinson, "On the Influence of the Nervous System in the Production of Disease, chiefly with reference to the Skin, Eye, and Joints."
ROYAL MICROSCOPICAL SOCIETY.—8 P.M. Professor Abbe: "New Method of Correcting Spherical Aberration"; Professor Abbe will also exhibit his Apparatus for demonstrating on a large scale the fundamental experiment of the theory of Microscopic Vision."—Mr. F. H. Wenham: "Note on Professor Abbe's Apertometer."—Dr. Fripp, "On the Theory of Illuminating Apparatus employed with the Microscope."

Thursday, June 12.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.
ST. BARTHOLOMEW'S HOSPITAL.—1½ P.M. Surgical Consultations.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.
ROYAL INSTITUTION.—3 P.M. Professor Karl Hillebrand, "On the Intellectual Movement of Germany from the Middle of the Last to the Middle of the Present Century."

Friday, June 13.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.
ST. THOMAS'S HOSPITAL.—Ophthalmic Operations, 2 P.M.
ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
ROYAL COLLEGE OF SURGEONS OF ENGLAND.—4 P.M. Professor Jonathan Hutchinson, "On the Influence of the Nervous System in the Production of Disease, chiefly with reference to the Skin, Eye, and Joints."
ROYAL INSTITUTION.—9 P.M. Mr. F. J. Bramwell: "The 'Thunderer' Gun Explosion."

Saturday, June 14.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.

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